

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00093

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MASS</u> MASS <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLINE</u> 58X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In car at Laurel Race Track</u>				d. STREET ADDRESS <u>211 ST PAUL ST.</u>			
3. NAME OF DECEASED (Type or print) <u>Frank</u>				4. DATE OF DEATH <u>1</u> <u>14</u> <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>61</u> yrs. <u>1</u> months <u>14</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HORSE OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RACE HORSES</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
13. FATHER'S NAME <u>SALVATORE ANDOLINO</u>				14. MOTHER'S MAIDEN NAME <u>EPISANIA ALESSI</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>PAUL ANDOLINO 211 ST. PAUL ST.</u>			
16. SOCIAL SECURITY NO. <u>024-03-2994</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Will. J. Ford</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/15/61</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/19/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ST MICHAEL</u>				22d. LOCATION (City, town, or country) (State) <u>Boston</u> <u>MASS.</u>			
23. FUNERAL DIRECTOR <u>Frank Della Voce</u>				24a. REC'D BY REGISTRAR <u>322 S. HIGH ST</u> 24b. REGISTRAR'S SIGNATURE <u>Jan 17 '61</u>			

10000

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

CERTIFICATE OF DEATH

C0094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH., D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2, Box 874 - SEVERN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE THERESA ANGLE</u>				4. DATE OF DEATH Month Day Year <u>JAN. 4th 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 MARCH 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES</u>	
13. FATHER'S NAME <u>JOS. ATWELL (DEC.)</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN (DEC.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>ELMER KING (son) RT 2, Box 874 - Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>CARDIO-VASCULAR-RENAL DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 YRS</u> <u>10 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FELL OUT OF BED 3 DAYS AGO - MASSIVE HEMORRH OF FACE & LT. LEG.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SEE ABOVE</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 1959</u> , to <u>present</u> , 1961, that I last saw the deceased alive on <u>JAN 3</u> , 1961, and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>H.F. Manuzak</u> M.D. <u>425 S. RITCHIE HWY</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>H.F. MANUZAK, M.D.</u> <u>GLEN BURNIE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MARSH PR. GEO CO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>				ADDRESS <u>C-577-119 SE WASH D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifton S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of funeral director		12. Signature of coroner	
13. Signature of health officer		14. Signature of medical examiner		15. Signature of pathologist	
16. Signature of undertaker		17. Signature of cemetery		18. Signature of burial place	
19. Signature of funeral home		20. Signature of funeral director		21. Signature of funeral director	
22. Signature of funeral director		23. Signature of funeral director		24. Signature of funeral director	
25. Signature of funeral director		26. Signature of funeral director		27. Signature of funeral director	
28. Signature of funeral director		29. Signature of funeral director		30. Signature of funeral director	
31. Signature of funeral director		32. Signature of funeral director		33. Signature of funeral director	
34. Signature of funeral director		35. Signature of funeral director		36. Signature of funeral director	
37. Signature of funeral director		38. Signature of funeral director		39. Signature of funeral director	
40. Signature of funeral director		41. Signature of funeral director		42. Signature of funeral director	
43. Signature of funeral director		44. Signature of funeral director		45. Signature of funeral director	
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49. Signature of funeral director		50. Signature of funeral director		51. Signature of funeral director	
52. Signature of funeral director		53. Signature of funeral director		54. Signature of funeral director	
55. Signature of funeral director		56. Signature of funeral director		57. Signature of funeral director	
58. Signature of funeral director		59. Signature of funeral director		60. Signature of funeral director	
61. Signature of funeral director		62. Signature of funeral director		63. Signature of funeral director	
64. Signature of funeral director		65. Signature of funeral director		66. Signature of funeral director	
67. Signature of funeral director		68. Signature of funeral director		69. Signature of funeral director	
70. Signature of funeral director		71. Signature of funeral director		72. Signature of funeral director	
73. Signature of funeral director		74. Signature of funeral director		75. Signature of funeral director	
76. Signature of funeral director		77. Signature of funeral director		78. Signature of funeral director	
79. Signature of funeral director		80. Signature of funeral director		81. Signature of funeral director	
82. Signature of funeral director		83. Signature of funeral director		84. Signature of funeral director	
85. Signature of funeral director		86. Signature of funeral director		87. Signature of funeral director	
88. Signature of funeral director		89. Signature of funeral director		90. Signature of funeral director	
91. Signature of funeral director		92. Signature of funeral director		93. Signature of funeral director	
94. Signature of funeral director		95. Signature of funeral director		96. Signature of funeral director	
97. Signature of funeral director		98. Signature of funeral director		99. Signature of funeral director	
100. Signature of funeral director		101. Signature of funeral director		102. Signature of funeral director	

18-11-11

TO HO. 4 may be retained by the hospital or attending death. AL DIRECTOR: After this certificate has been TO FUN. director, page 3 should be detached to 15M 9.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

085

CERTIFICATE OF DEATH

00095

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 513 Fifth St.,			
3. NAME OF DECEASED (Type or print) Katherine				4. DATE OF DEATH Month January Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1905	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 25 Hours 19 Min. 61		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Travis				14. MOTHER'S MAIDEN NAME Hanna Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mary S.S. Vauls - 513 Fifth St. Anna. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cardiac Failure DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) was not present attended the deceased from Jan. 25, 1961 to Jan. 25, 1961, that (I) was not saw the deceased alive on Jan. 25, 1961, and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE A. T. Allen				22b. DATE SIGNED 1/26/61			
22c. PHYSICIAN'S NAME (Type) A. T. Allen				22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-61		23c. NAME OF CEMETERY OR CREMATORY Good Hope		23d. LOCATION (City, town or county) (State) Front Royal - Va.	
24 FUNERAL DIRECTOR'S SIGNATURE C.E. HICKS				25a. REC'D BY REGISTRAR JAN 31 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. REGISTRAR'S SIGNATURE			

24 hours after

executed

physician.

MEDICAL CERTIFICATION

(4)

60

1945

1945

(1)

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

3. The third part of the report is a statement of the work done by each of the individuals in the various departments. It is a summary of the work done by each of the individuals and is intended to give a detailed impression of the work done during the year.

4. The fourth part of the report is a statement of the work done by each of the committees in the various departments. It is a summary of the work done by each of the committees and is intended to give a detailed impression of the work done during the year.

5. The fifth part of the report is a statement of the work done by each of the sub-committees in the various departments. It is a summary of the work done by each of the sub-committees and is intended to give a detailed impression of the work done during the year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

086

CERTIFICATE OF DEATH

00083

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN lb - d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1536 N. Milton St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BARNETT Middle - Last -		4. DATE OF DEATH Month JANUARY Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12:11 PM 22 Jan 61
9. AGE (In years last birthday) - yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Mins 19	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? -		13. FATHER'S NAME Alvin Barnett	
14. MOTHER'S MAIDEN NAME Janice Wilburn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or at unknown) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Mother - 1536 N. Milton St Balto, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia: - aspiration of amniotic contents. DUE TO 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Questionable sub-dural hemorrhage. DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from 21 Jan 19 61 to 22 Jan 19 61 that (I) last saw the deceased alive on 22 Jan 19 61 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Roy M. Slezak		22b. DATE SIGNED 22 Jan 61	
22c. PHYSICIAN'S NAME (Type) ROY M. SLEZAK, Capt., M.C.		22d. ADDRESS US Army Hosp Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 30 Jan 61	
23c. NAME OF CEMETERY OR CREMATORY U. S. A. Hosp		23d. LOCATION (City, town, or county) (State) Ft Geo G. Meade, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Landon and H. H. Hise		25a. REC'D BY REGISTRAR 22 Jan 61	
ADDRESS 2050 20th St		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 231 Asbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Warren Le Roy BEVAN				4. DATE OF DEATH Month Day Year January 12 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1884			
9. AGE (In years lost birth day) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Davis Chem. Co.		11. BIRTHPLACE (State or foreign country) Williamsport, Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME Joseph Bevan				14. MOTHER'S MAIDEN NAME Clara ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Warren L. Bevan 231 Asbury Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Hemorrhage Secondary to DUE TO (c) Chronic Duodenal Ulcer.								INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Resection on 7/6/61								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from 1/4 1961 , to 1/12 1961 that (I) did not last saw the deceased alive on 1/12 1961 , and that death occurred at 6:25 P. M. from the causes and on the date stated above.									
22a. SIGNATURE J. Fred Hawkins, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/12/61			
22c. PHYSICIAN'S NAME (Type) J. Fred Hawkins, Jr.				22d. ADDRESS 100 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/61		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Tucker & Sons				ADDRESS Balto 17, Md		25a. REC'D BY REGISTRAR DATE JAN 13 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00097

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Res.</u>		d. STREET ADDRESS <u>14921 BROOKWOOD RD</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>S</u> Last <u>BLAKEN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 3 - 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) yrs. <u>83</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Francis Beall</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET YEATLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>MR. WM. H. BLAKEN</u>		Address <u>4921 BROOKWOOD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>June 15, 1956</u> , to <u>June 13, 1961</u> , that I last saw the deceased alive on <u>11/3/61</u> , 19 <u> </u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel L. Miller</u> M.D.		DATE SIGNED <u>203</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-17-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN P. MILLER</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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60098

1. PLACE OF DEATH a. COUNTY <u>Adams</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Turners Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Brown</u>		4. DATE OF DEATH <u>1</u> <u>14</u> <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John W. Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, honor unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Richard Thomas Lathrop MD</u>		17. INFORMANT <u>Richard Thomas Lathrop MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Retrospective Hypertensive Cardio</u> DUE TO (c) <u>Vascular disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o m p. m. Month. Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>1/14/61</u> , that (I) (we) last saw the deceased alive on <u>1/14/61</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>R. R. Richardson</u>		22b. DATE SIGNED <u>1/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Richardson M.D.</u>		22d. ADDRESS <u>10-27-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Adams Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Bayard Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reed H. Arnsperg</u>		25. REGISTRAR'S SIGNATURE <u>William Reed H. Arnsperg</u>	
26. REC'D BY REGISTRAR <u>JAN 27 '61</u>		27. DATE	



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FOR STATE
HEALTH DEPT.

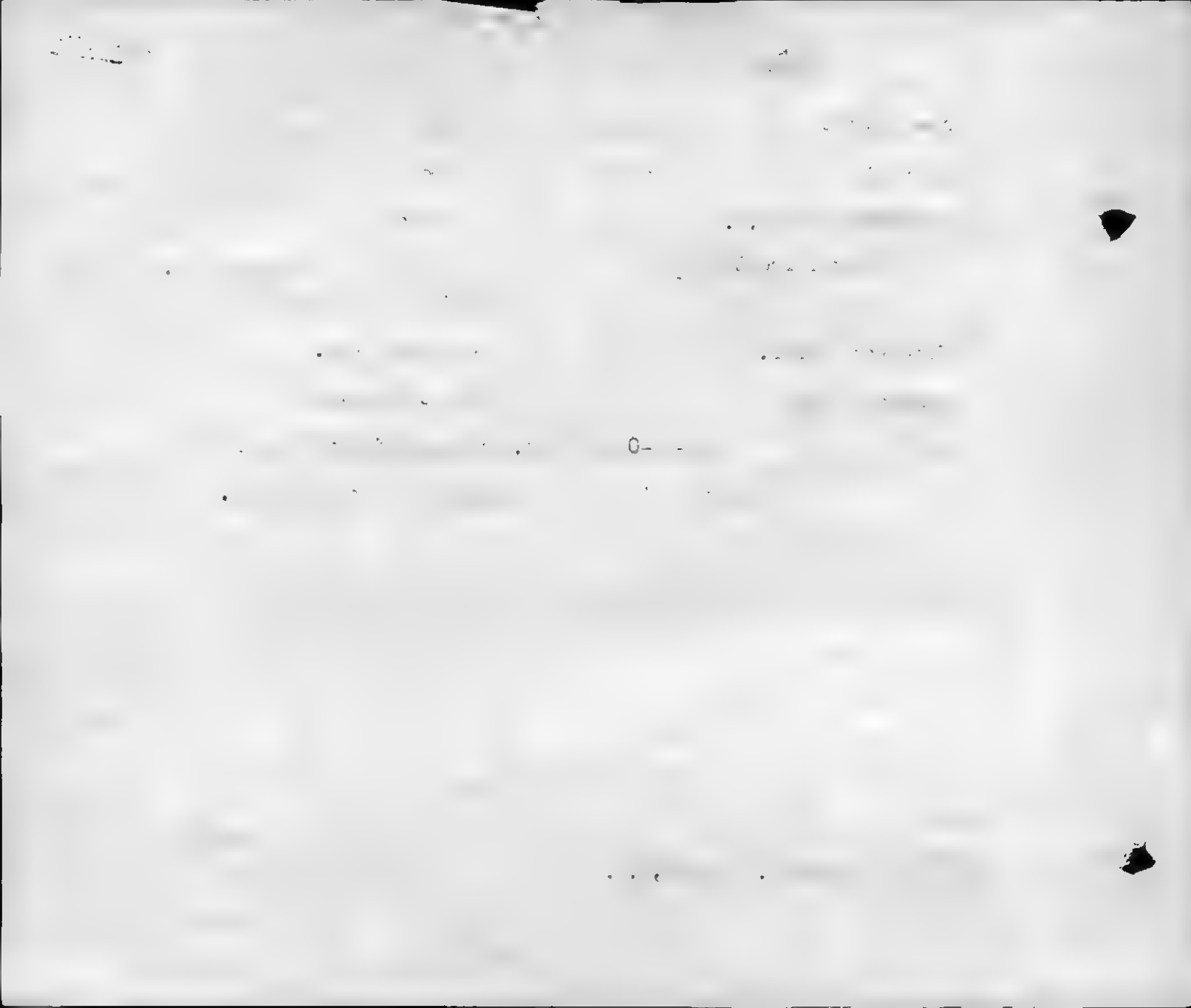
TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
050														
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND					c. LENGTH OF STAY IN 1b 6 months					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 411 Sixth Street N.E.					4. DATE OF DEATH Date of Death Last Same First James Middle Forrest Last Burns					9. AGE (in years, last birthday) January 30th, 19 61 85 yrs. Months 0 Days 0 Hours 0 Min. 0				
3. NAME OF DECEASED (Type or print) James Forrest Burns					5. SEX M					6. COLOR OR RACE W				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 12/25/75					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner.					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Bellewood Penn.				
13. FATHER'S NAME Alexander Burns					14. MOTHER'S MAIDEN NAME Rhoda Culberston					12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 236-09-0332					17. INFORMANT Mrs. Etheline Gilbert (daughter)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular diseases, Diabetes. 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443 X DUE TO (c) 443 X DUE TO					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH ?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					22. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 2-2-61					22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.				
22d. LOCATION (City, town, or country) (State) Glen Burnie, Md.					23. FUNERAL DIRECTOR K. J. Singleton					24a. REC'D BY REGISTRAR Glen Burnie, Md.				
24b. REGISTRAR'S SIGNATURE Glen Burnie, Md.					24c. DATE FEB 6 '61					24d. REGISTRAR'S SIGNATURE Glen Burnie, Md.				

00099



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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091
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CO100

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDDIE</u> Middle <u>CAHOWELL</u> Last <u>CAHOWELL</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1908</u> AGE (In years last birthday) <u>52</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tractor</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>James A. Wells</u>		Address <u>325 N. Wendell Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4431</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure due to</u> DUE TO (c) <u>Arteriosclerotic Hypertensive Cardio-vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/23/1960</u> to <u>1/1/1961</u> , that (I) (we) last saw the deceased alive on <u>1/1/1961</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED <u>1/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson M.D.</u>		22d. ADDRESS <u>110-CLAY ST ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)
<u>Burial</u>	<u>1-7-1961</u>	<u>Brewer Hill</u>	<u>Annapolis Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Anna M. D.</u>			



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 092
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

C0101

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crown St. LLE</u>		c. LENGTH OF STAY IN 1b <u>12/26/56</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3414</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREENSVILLE STATE HOSPITAL</u>				d. STREET ADDRESS <u>1729 N SMALLWOOD STR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LONNIE</u> First <u>CHAPMAN</u> Middle Last				4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1914</u>	9. AGE (In yrs. last day) <u>46</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown to us</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown to us H.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown to us</u>				14. MOTHER'S MAIDEN NAME <u>unknown to us</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>chronic brain syndrome associated with generalized arteriosclerosis</u> DUE TO (c) <u>with generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/26/56</u> 19 to <u>1/4/61</u> 19, that (I) (we) last saw the deceased alive on <u>1/24/61</u> 19, and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				22d. ADDRESS <u>Greenville State Hospital</u>			
23a. BURIAL OR CREMATION REMOVAL (Specify)		23b. DATE THEREOF <u>1-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		23d. LOCATION (City, town, or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patonsville</u>		c. LENGTH OF STAY IN TB <u>2 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patonsville</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital, Patonsville, Md.</u>				d. STREET ADDRESS <u>173 Cherrydell Road</u>								
3. NAME OF DECEASED (Type or print) First <u>Luthor</u> Middle <u>Glen</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1961</u>								
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spring Grove State Hospital, Prince George's County, Md.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>								
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Andrew J. Collins</u>								
14. MOTHER'S MAIDEN NAME <u>Rosa Burke</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>								
16. SOCIAL SECURITY NO. <u>228 01 0605</u>		17. INFORMANT <u>Jesse W. Collins, Same as 2.</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </td> </tr> <tr> <td colspan="2"> DUE TO (b) _____ </td> </tr> <tr> <td colspan="2"> DUE TO (c) _____ </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	DUE TO (b) _____		DUE TO (c) _____	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>										
DUE TO (b) _____												
DUE TO (c) _____												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While walking on sidewalk</u>										
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> o. m. <u>1/19/61</u> 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>On sidewalk</u>								
20f. (City or town) <u>Patonsville</u>		20g. (County) <u>Prince George's</u>		20h. (State) <u>Md.</u>								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Gustave K. Paubert, M.D.</u>		EXAMINER'S NAME (Type) <u>Gustave K. Paubert, M.D.</u>		DATE SIGNED <u>1/20/61</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Cove</u>								
22d. LOCATION (City, town, or county) <u>Big Stone Gap, Va.</u>		22e. (State) <u>Va.</u>										
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. + Don Co</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 24 '61</u>								
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>				24c. (Address) <u>28</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



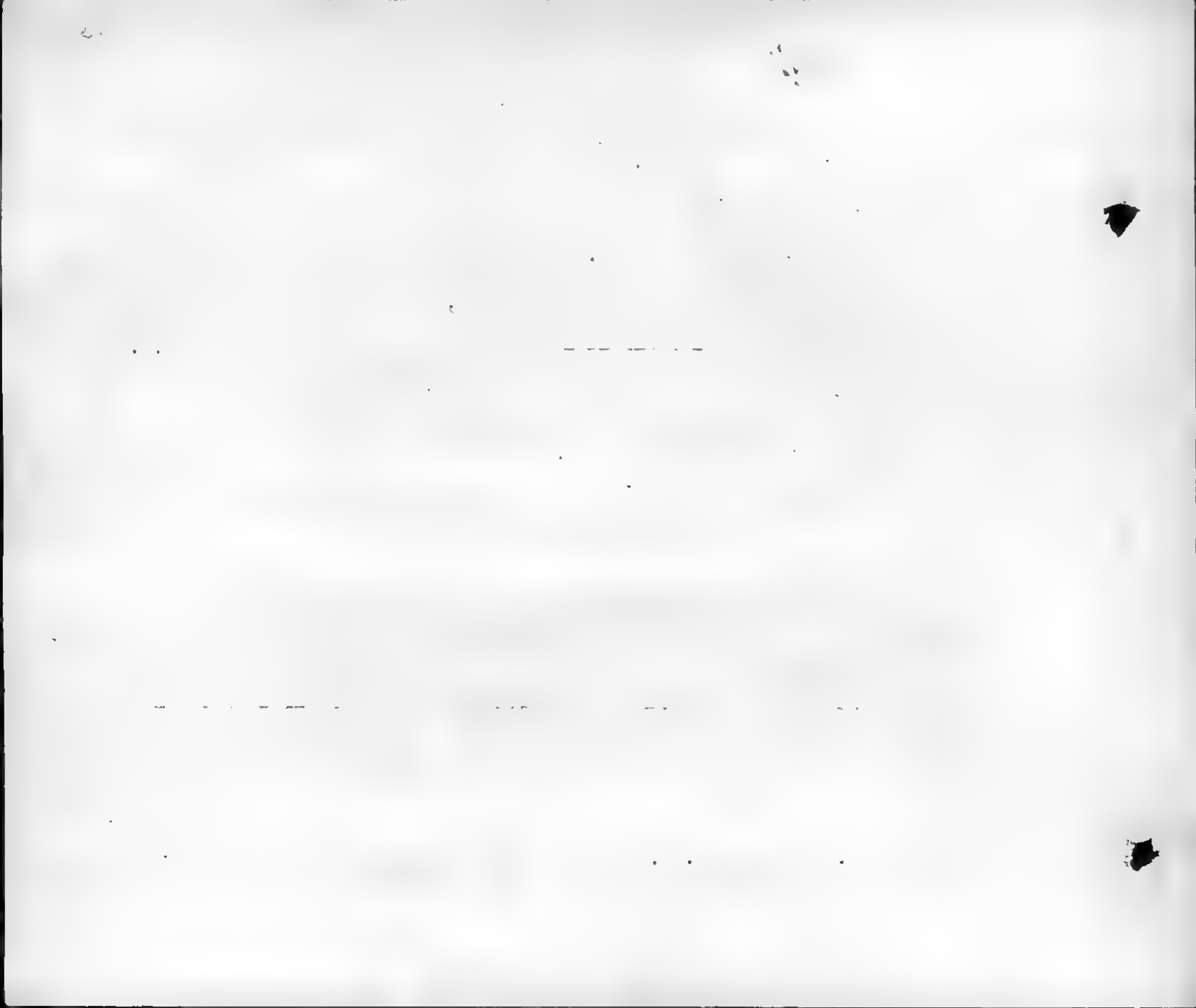
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0103

094

1. PLACE OF DEATH a. COUNTY Anna Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 year 9 mos. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge C913			
				d. STREET ADDRESS Pine & Cross Streets			
3. NAME OF DECEASED (Type or print) First George Middle W. Last Cornish				4. DATE OF DEATH Month 1 Day 10 Year 19 61			
5 SEX Male		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1896	
				9 AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Cornish				14. MOTHER'S MAIDEN NAME Isabella Laws			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
						Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 162.1 DUE TO Bronchogenic Carcinoma Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 4/6/1959 to 1/10/1961 , that (I) (we) last saw the deceased alive on 1/10/1961 , and that death occurred at 8:45 from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> January 10, 1961		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/11/61		23c. NAME OF CEMETERY OR CREMATORY Camb.		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Funeral				25a. REC'D BY REGISTRAR JAN 13 '61		25b. REGISTRAR'S SIGNATURE <i>C. L. S. House</i>	
				ADDRESS 222 Cedar St Camb			



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

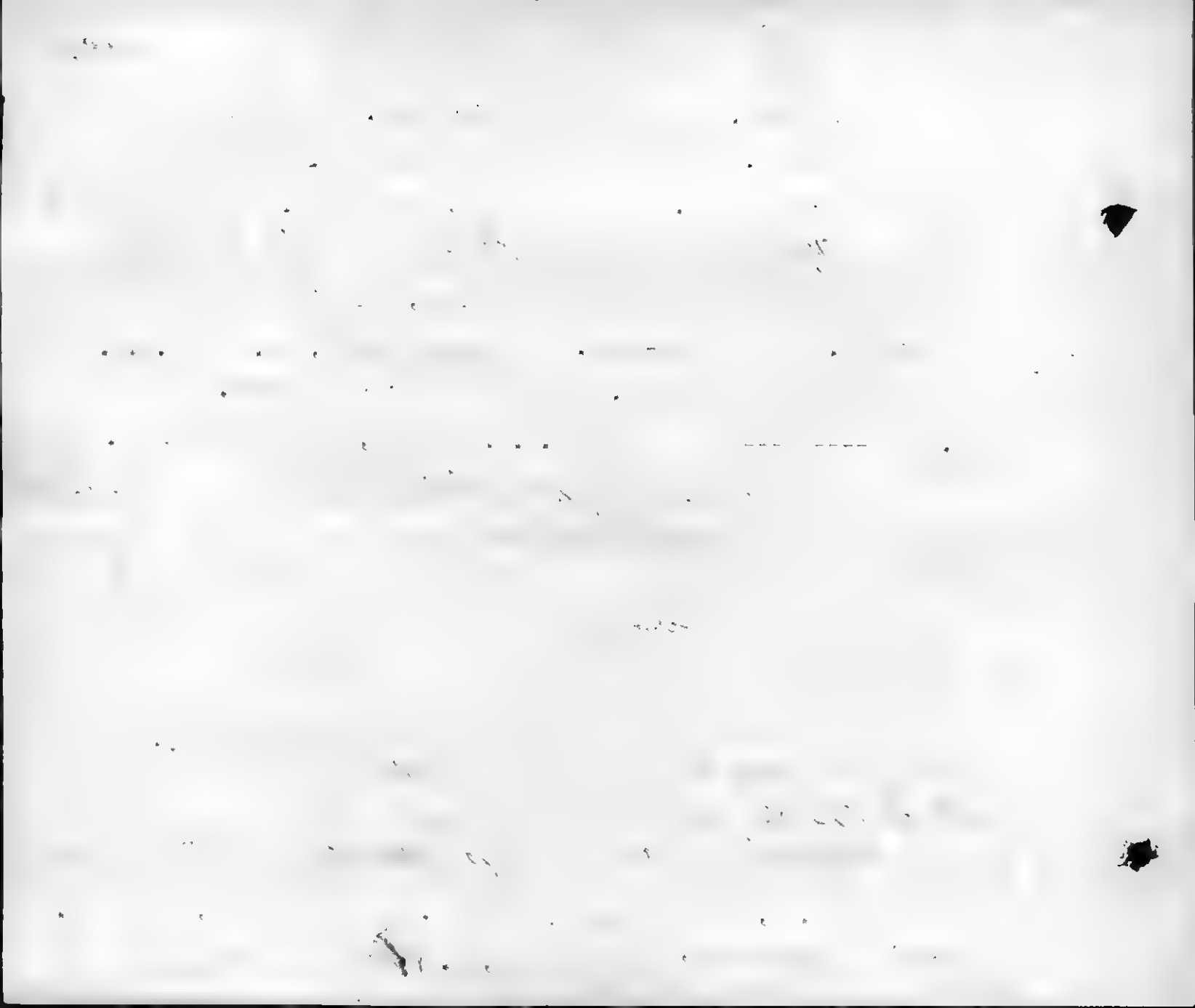
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

095

CERTIFICATE OF DEATH

00104

1. PLACE OF DEATH a. COUNTY Anne Arundale. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Nursing Home.				d. STREET ADDRESS Route #1 Box 240.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Davis				4. DATE OF DEATH Month Jan. Day 17 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17th, 1891		9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic.		10b. KIND OF BUSINESS OR INDUSTRY Own-Work.		11. BIRTHPLACE (State or foreign country) Louisa County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Marion Melten.				14. MOTHER'S MAIDEN NAME Dora Madison.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mr. A. A. Dadidson, Millersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the uterus 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1 1951 to Jan 17 1961 , that (I) last saw the deceased alive on Jan 16 1961 , and that death occurred at 9 A.M. from the causes and on the date stated above							
22a. SIGNATURE A. M. McLaughlin				22b. DATE SIGNED 1/17/61			
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin				22d. ADDRESS 3708 Mountain Rd, Pasadena Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery.		23d. LOCATION (City, town, or county) (State) Gordonsville, Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE Preddy's Funeral Home, Gordonsville, Va.				25a. REC'D BY REGISTRAR J. W. Freedy		25b. REGISTRAR'S SIGNATURE Arthur H. ...	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
096 CERTIFICATE OF DEATH

C0105

1. PLACE OF DEATH a. COUNTY <u>GA Co Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>GA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brenton GA Co Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knoll Manor Home</u>		d. STREET ADDRESS <u>1 Mullersville GA Co Md</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>A</u> Last <u>DISNEY.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Murray</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Kathryn Parker</u> Address <u>17 George Ave</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL CORTICAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DUE TO (b) <u>CEREBRO VASCULAR OCCLUSION</u>		<u>2 months</u>	
DUE TO (c) <u>CEREBRAL THROMBOSIS</u>		<u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ATHEROMA.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/60</u> to <u>1/5/61</u> , that (I) (we) last saw the deceased alive on <u>1/2/61</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH.</u>		22d. ADDRESS <u>121 CATHEDRAL ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 9-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>		23d. LOCATION (City, town, or county) <u>Fredensburg Rd Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard's Link</u> ADDRESS <u>426 Green Bay</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60106

1. PLACE OF DEATH a. COUNTY <u>ANNE-ARUNDEL</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON</u> c. LENGTH OF STAY IN IT <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Michaels</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>SAME</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAME</u> d. STREET ADDRESS <u>SAME</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GROVER-CLIFTON-DORSEY</u> First Middle Last 4. DATE OF DEATH <u>JAN-31</u> Month Day Year <u>1961</u>				5. SEX <u>M.</u> 6. COLOR OR RACE <u>C.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/7/93</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from P.R.R. AS-LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rutland & Co. Ind.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>NICHOLAS-DORSEY</u>				14. MOTHER'S MAIDEN NAME <u>SUZANNE-QUEEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>717-07-6554</u> 17. INFORMANT <u>Eugenia Dorsey (wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>GUSTAVE-H. FAUBERT</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1/2/61 DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Steuersville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabo</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton Md.</u>	
23. FUNERAL DIRECTOR <u>William Reese</u> ADDRESS <u>Anna, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

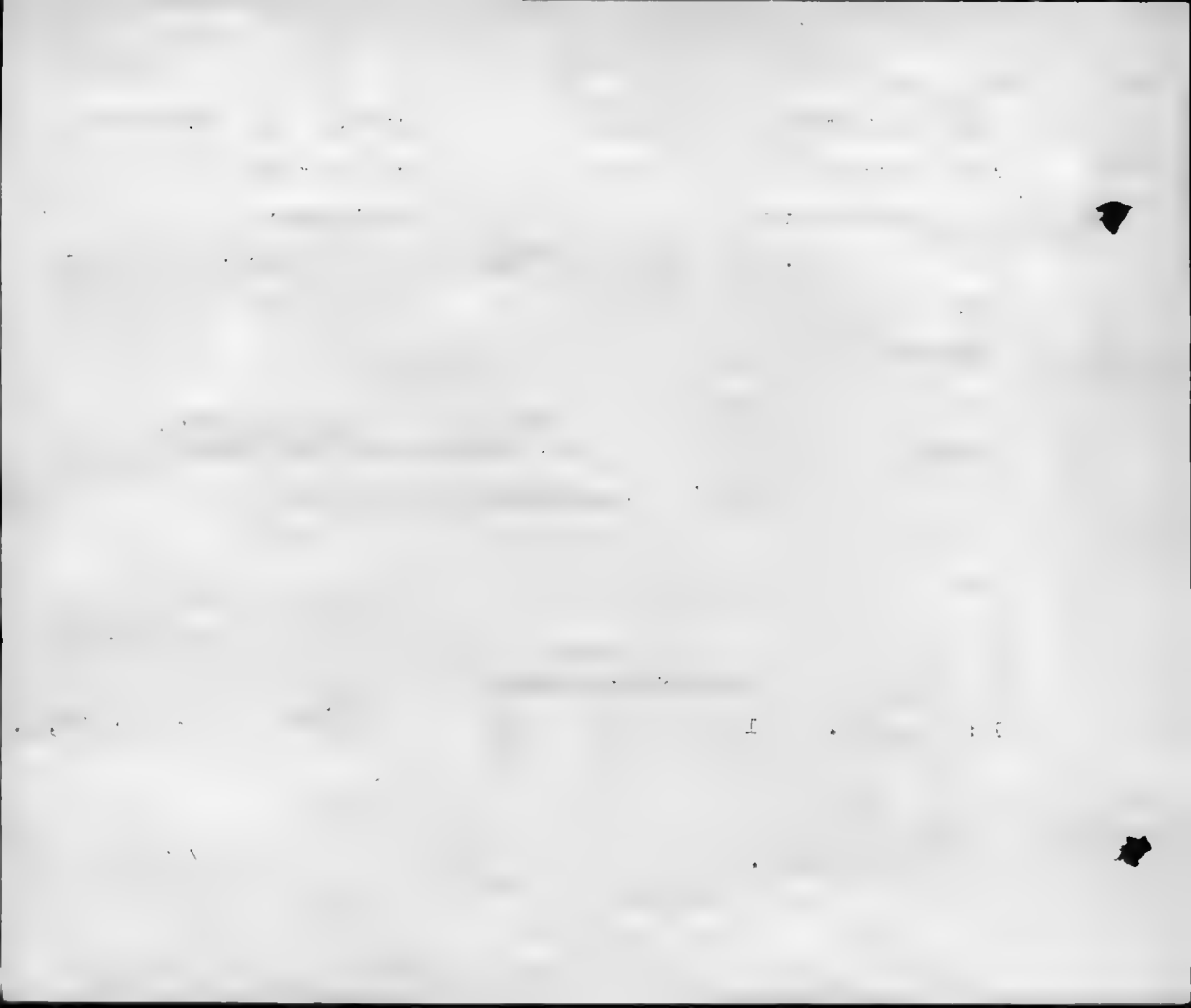
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60107

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>rural Churchton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Churchton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Franklin Manor</u>		d. STREET ADDRESS <u>Franklin Manor</u>	
3. NAME OF DECEASED (Type or print) <u>H. MALONE DRESBACH</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		11. BIRTHPLACE (State or foreign country) <u>Hotel Kansas</u>	
13. FATHER'S NAME <u>Ralph Spencer Dresbach</u>		14. MOTHER'S MAIDEN NAME <u>Anna Malone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>181X</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds of face and trunk</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>shot during altercation</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot during altercation</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:00 Jan. 7 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Churchton Anne Arundel, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN</u>		22d. LOCATION (City, town, or country) (State) <u>ELK CITY KANSAS</u>	
23. FUNERAL DIRECTOR <u>Benedict Hardisty</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>	
ADDRESS <u>Washington DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

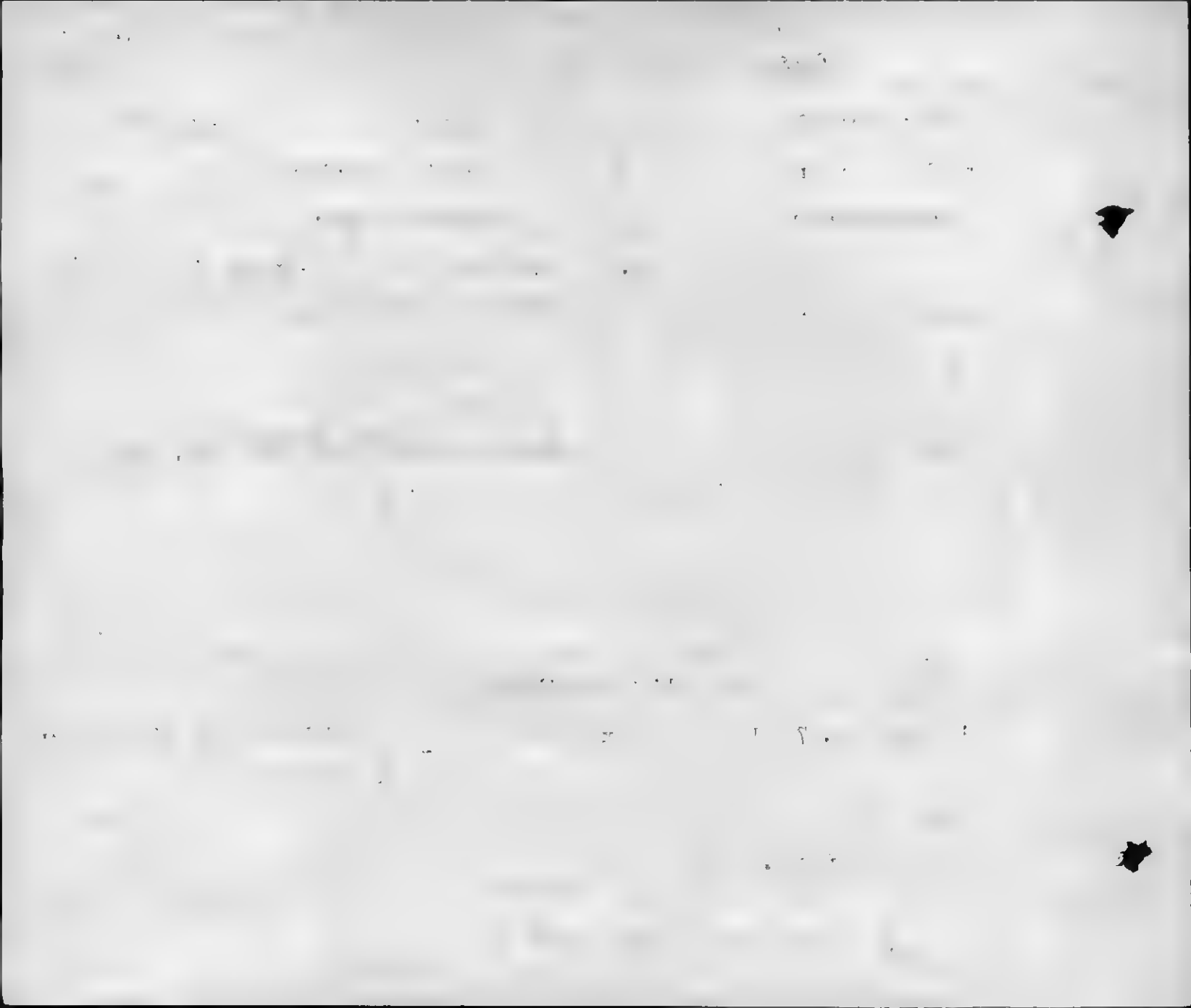
VS. A15ME
5M 7/59

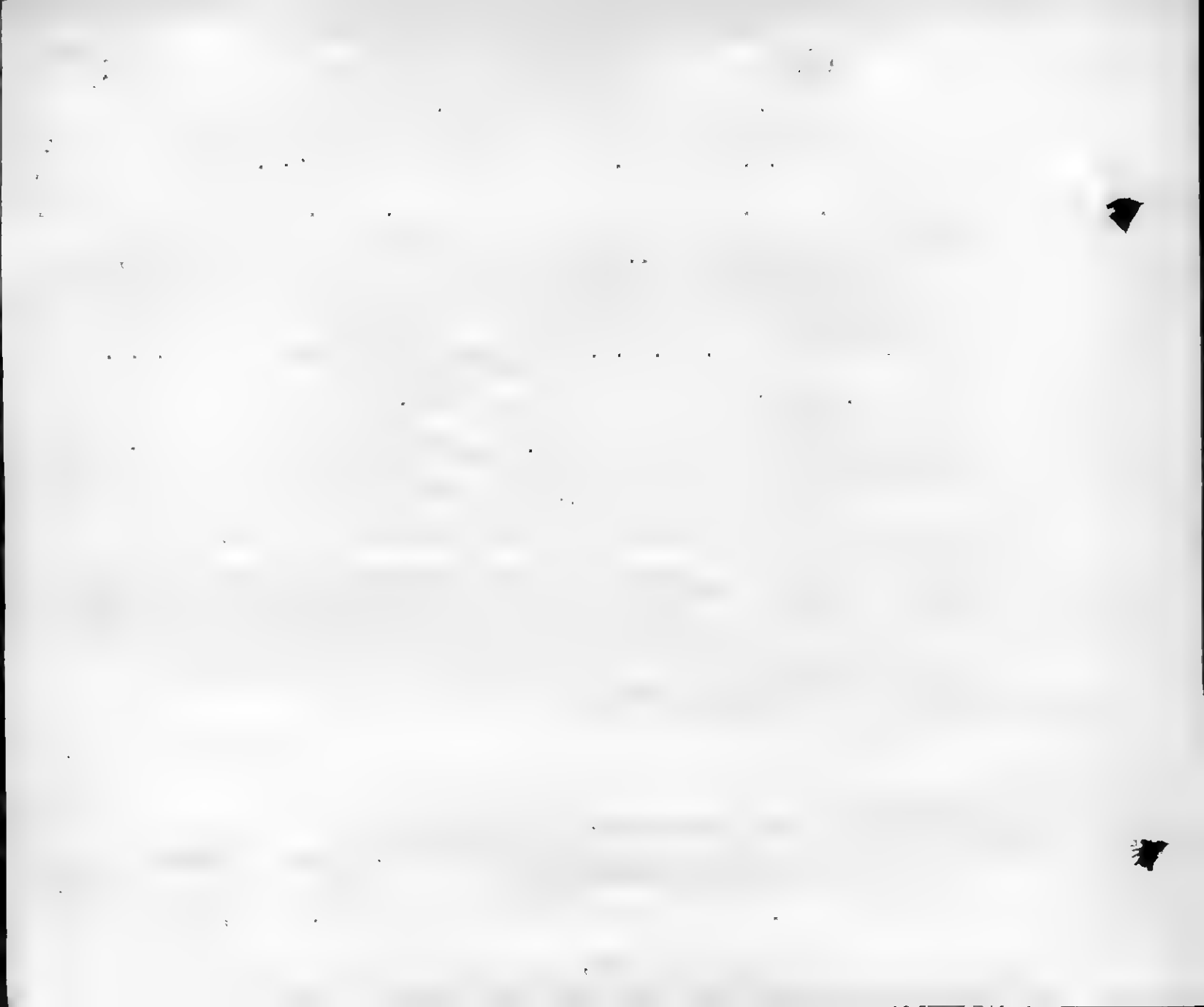
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00108

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Churchton		c. LENGTH OF STAY IN 1b 2 YRS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Churchton		d. STREET ADDRESS Franklin Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) SHIRLEY S. DRESBACH		4. DATE OF DEATH January 7 1961		5. SEX female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 28 1913		9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIK City, Kansas		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James A. R.		14. MOTHER'S MAIDEN NAME Grace L. R. R.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Harry Woodring		17. INFORMANT Woodner Hotel Washington, D.C.		18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of trunk DUE TO (b) shot during altercation DUE TO (c) shot during altercation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) shot during altercation		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. shot during altercation		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot during altercation		20c. TIME OF INJURY Month, Day, Year 10:00 AM Jan. 7 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Churchton Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/61		22c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		22d. LOCATION (City, town, or country) (State) FAIR CITY KANSAS		23. FUNERAL DIRECTOR Bernard Harduty		24a. REC'D BY REGISTRAR Charles S. Petty		24b. REGISTRAR'S SIGNATURE Charles S. Petty		24c. DATE JAN 16 '61		24d. ADDRESS (Street, city, town, or county) 1/8/61							

MEDICAL CERTIFICATION





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CO110

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Arnold		c. LENGTH OF STAY IN lb 8 months		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY A.A. Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 2 Box 3				d. STREET ADDRESS Rt. # 2 Box 3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George		Middle L.		Last Duvall		4. DATE OF DEATH Month Jan.		Day 16	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1899		9. AGE (In years lost birthday) 61 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Mechanic		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Mack Duvall				14. MOTHER'S MAIDEN NAME Ellen Lewis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO (If yes, give year or dates of service) 231-01-9116		17. INFORMANT Family		Address Above			

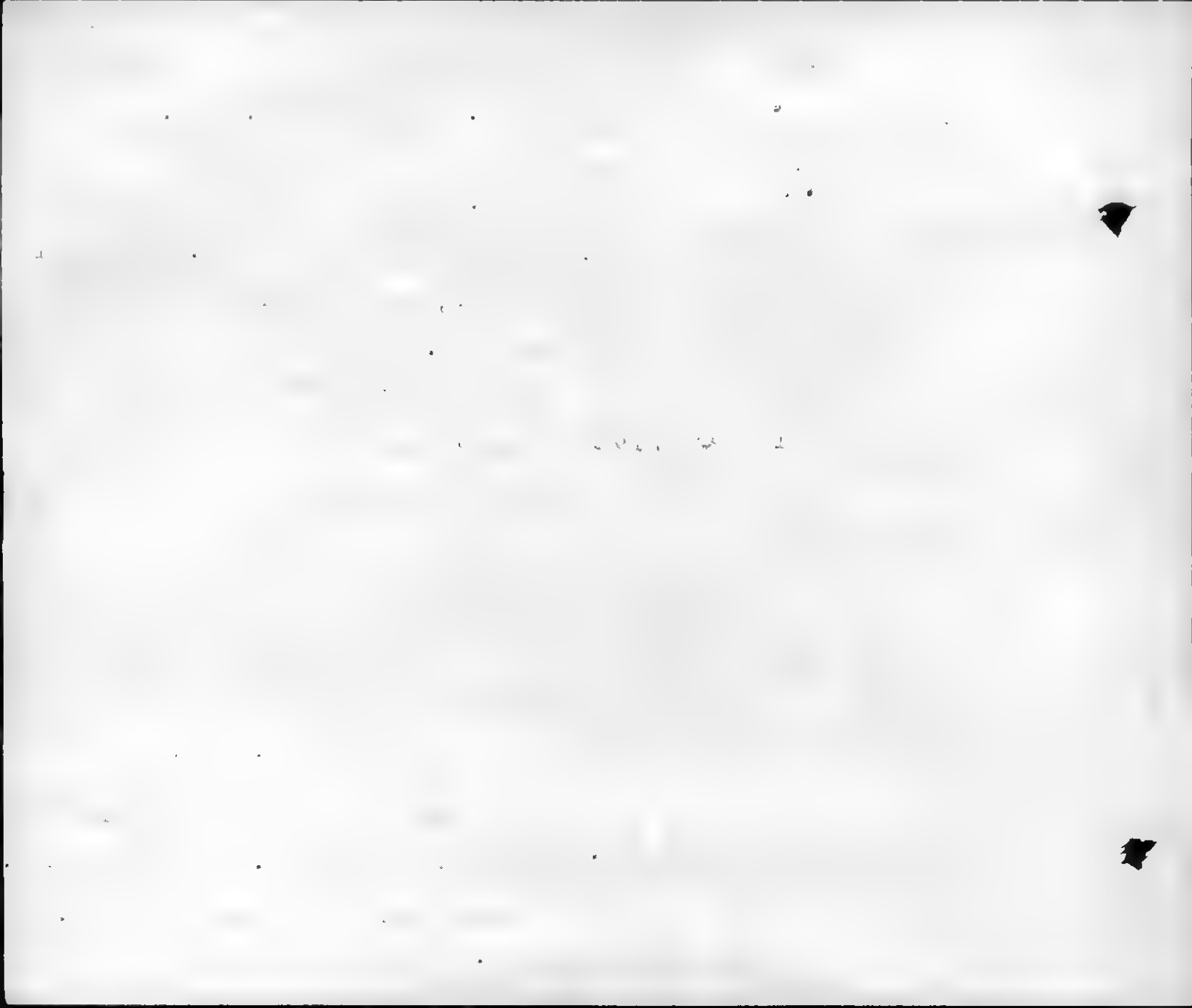
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1960 to Jan 1961 , that (I) (we) last saw the deceased alive on Jan 1 1961 , and that death occurred at 6 PM , from the causes and on the date stated above	
22a. SIGNATURE Francis I. Codd, Md.	22b. ADDRESS Gov. Ritchie Hwy. Severna Park, Md.
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS

23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 1/20/61	23c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem.	23d. LOCATION (City, town, or county) (State) Annapolis Md.
24. FUNERAL DIRECTOR'S SIGNATURE Phil S. Barranco		25a. REC'D BY REGISTRAR JAN 19 61	25b. REGISTRAR'S SIGNATURE



1
FOR STATE
HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY **A.A. Co**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, **Rural**)
c. LENGTH OF STAY IN 1b **D.O.A.**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **D.O.N. Anne Arundel General**

2. USUAL RESIDENCE (Where deceased lived, if not last one, Residence before admission)
a. STATE **MD** b. COUNTY **A MONTGOMERY**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Silver Spring 95 - MD**
d. STREET ADDRESS **814 SILVER SPRING AVENUE** e. IS RESIDENCE ON A FARM? **YES** ☐ **NO** ☒

3. NAME OF DECEASED (Type or print) **JOHN (NMI) FERGUSON**
4. DATE OF DEATH **1 20 1961**

5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **7/7/05**
8. WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) **55** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Bricklayer** 10b. KIND OF BUSINESS OR INDUSTRY **J. B. Kelly Co.** 11. BIRTHPLACE (State or foreign country) **Scotland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **WILLIAM FERGUSON** 14. MOTHER'S MAIDEN NAME **CATHERINE WHITELAW**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO **220-38-4394** 17. INFORMANT **Mrs. Helen Ferguson, 814 Silver Spring Ave. Silver Spring, Md.** Address **Silver Spring, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Fracture Skull**
812x DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c) DUE TO
(e), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH **Auto accident Ph 50 -- Pedestrian**
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **1-20 1961** 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Route 50** 20f. (City or town) **AACO** (County) **MD** (State)

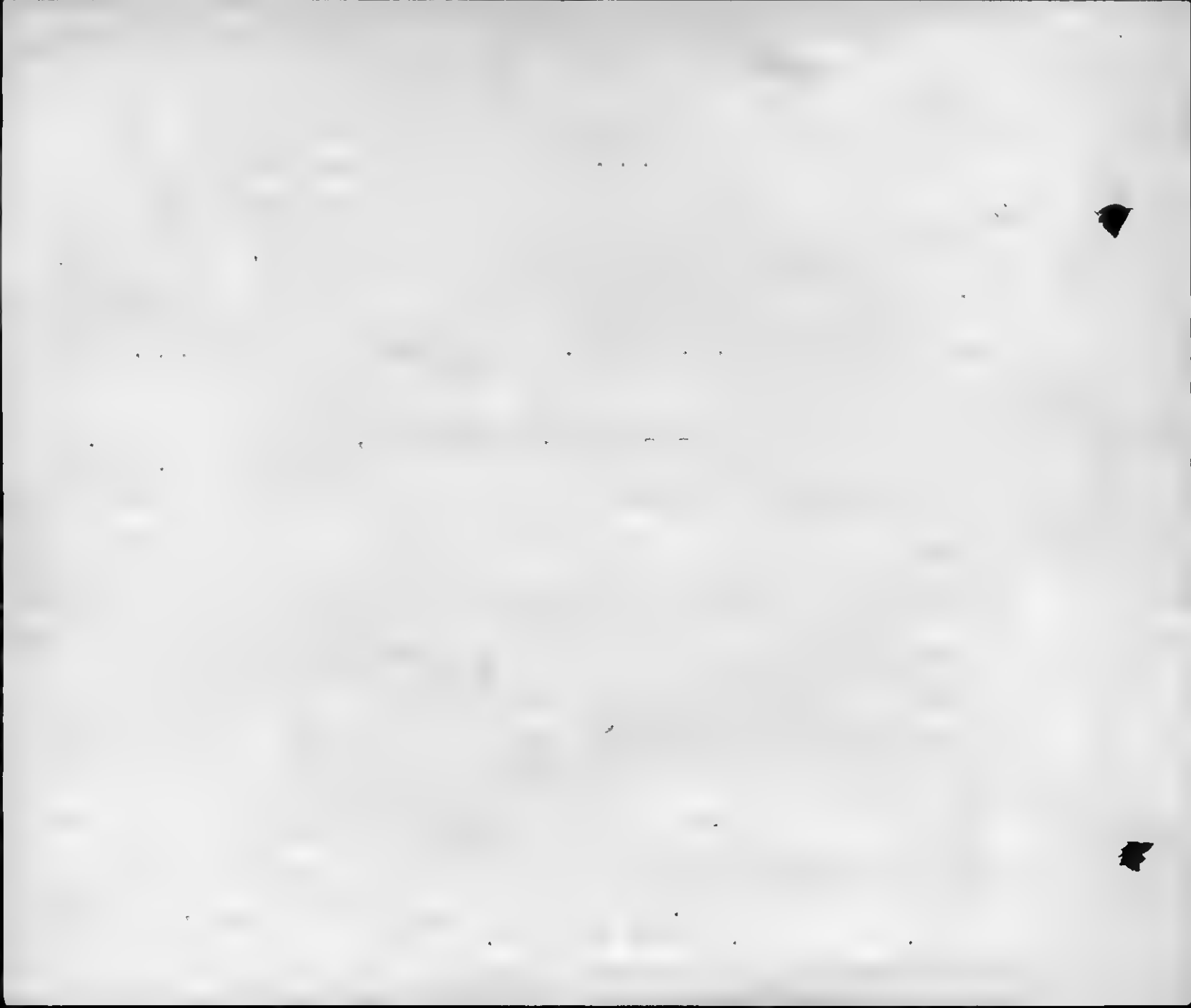
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **E. Linhart** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **E. Linhart** DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **1-20-61**

22a. BURIAL, CREMATION, REMOVAL (Specify) **CREMATION** 22b. DATE THEREOF **1/24/61** 22c. NAME OF CEMETERY OR CREMATORY **FT. LINCOLN CREMATORY** 22d. LOCATION (City, town, or country) (State) **PRINCE GEO. COUNTY, MARYLAND**

23. FUNERAL DIRECTOR **Raymond A. Giska** ADDRESS **SILVER SPRING, MD.** 24a. REC'D BY REGISTRAR **JAN 26 '61** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

CU111



1
FOR STATE
HEALTH DEPT.

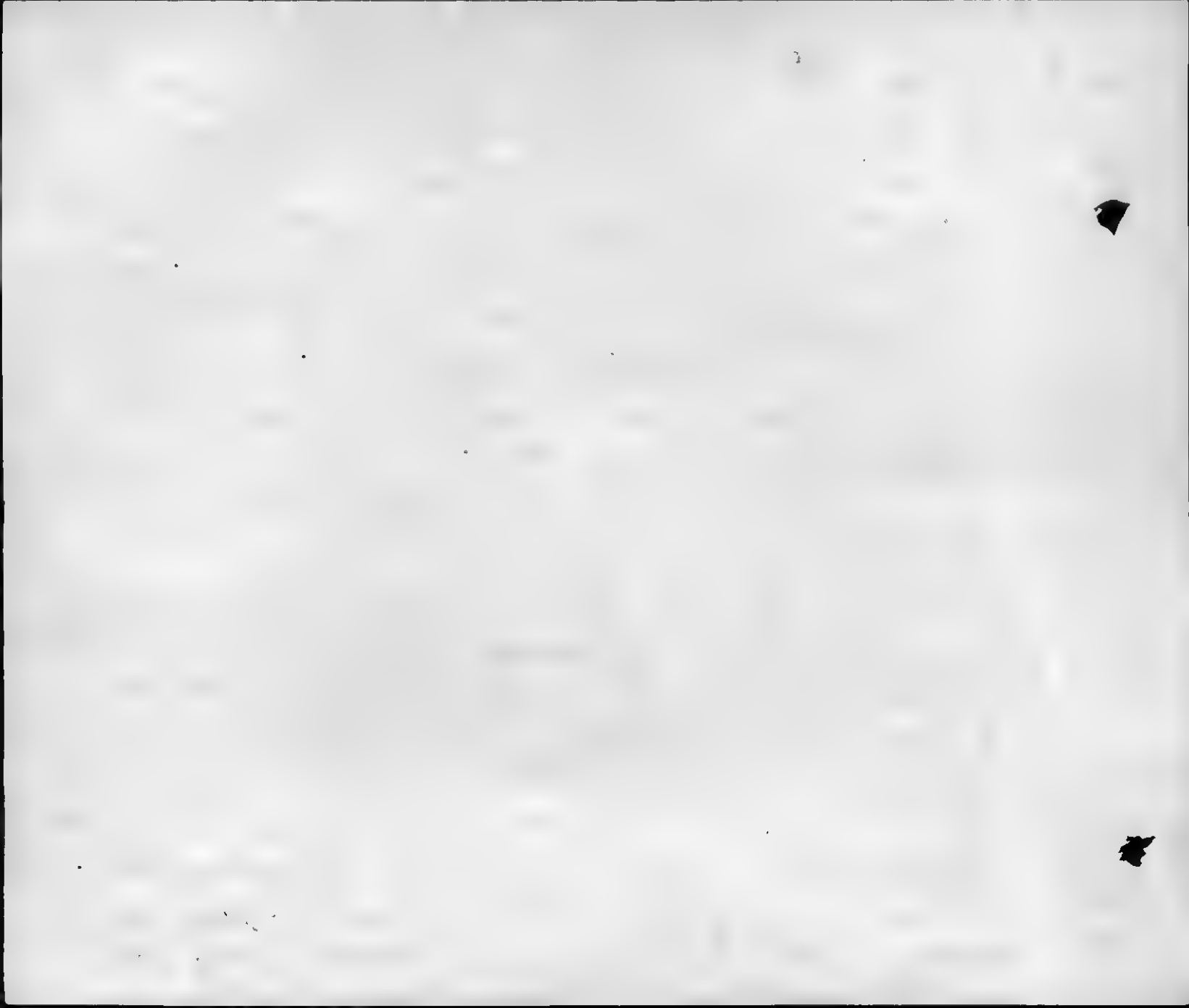
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60112

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Detrick</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>409 N. Ritchie Highway</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Detrick</u> d. STREET ADDRESS <u>1111 1st St. S.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Butt, Alice Pierick</u> First Middle Last				4. DATE OF DEATH <u>January 10, 1961</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1917</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>12-345678</u>		17. INFORMANT <u>Husband</u> Address <u>1111 1st St. S.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Pulmonary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Hopping</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/5/61</u>					
EXAMINER'S NAME (Type) <u>Gustave H. Hopping</u>		Address (Street, city, town, or county) <u>Green Mount Cem. Philadelphia, PA.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, PA.</u>	
23. FUNERAL DIRECTOR <u>Hopping & Kirkney, Glen Burnie</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Hanning</u>		24b. REGISTRAR'S SIGNATURE	



1 FOR STATE HEALTH DEPT.

TO DEPARTMENTAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

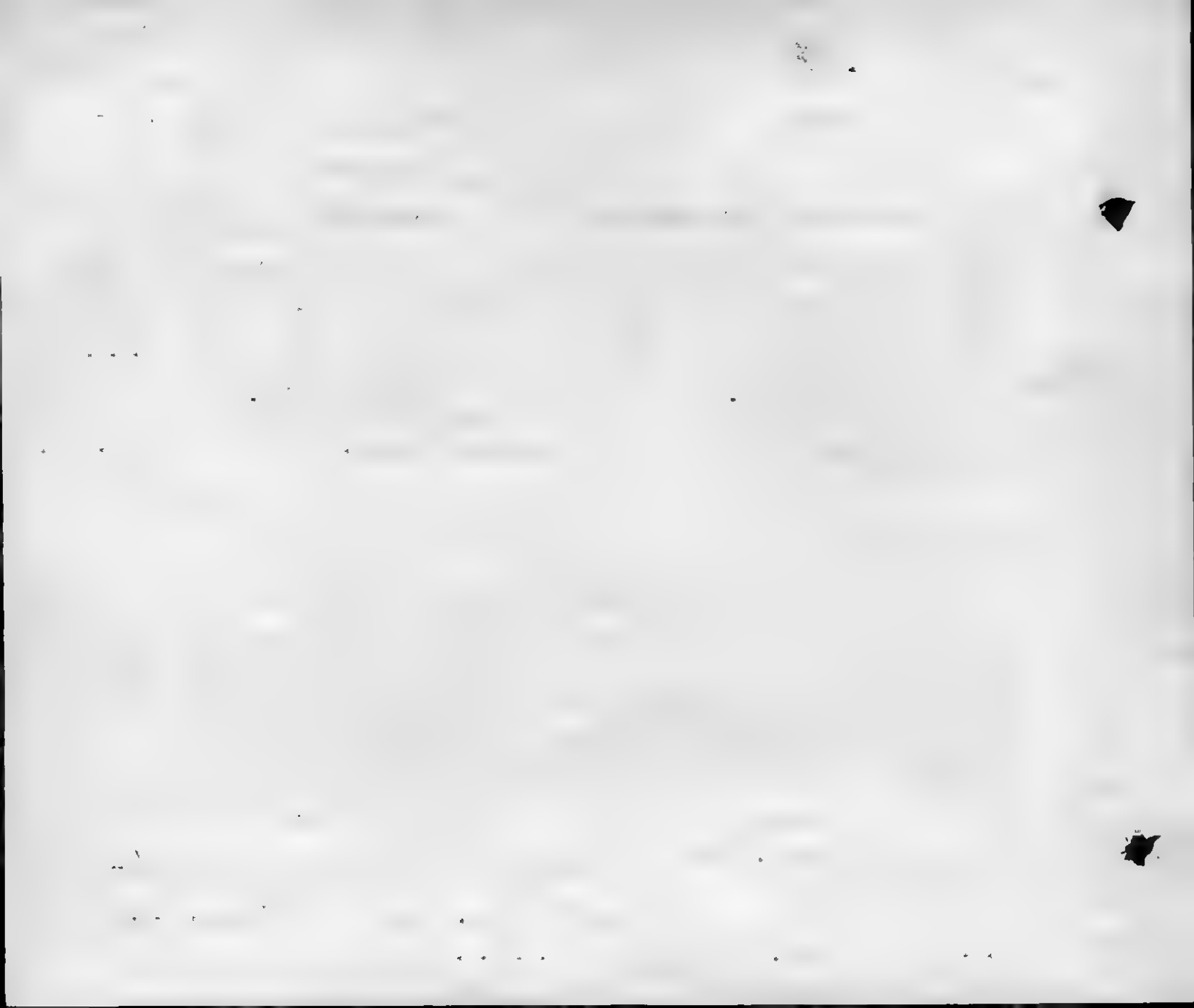
VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Anne Arundel		Annapolis		Maryland		Anne Arundel	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Anne Arundel General Hospital				Crownsville		Whitney Drive	
3. NAME OF DECEASED (Type or print)		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
PATRICIA FIGULO		female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Wife		Home		P. C.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
Michael M O'Meara.		Flornene T King.		No		No	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. WAS AUTOPSY PERFORMED?		INTERVAL BETWEEN ONSET AND DEATH	
Mr Walter O'Meara.		Bilateral Pneumonia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Riverdale Md. Bro.		491X					
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO			
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
Hour a.m. p.m.		19					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from.		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		DATE SIGNED	
ACTUAL SIGNATURE		Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty		Address (Street, city, town, or county)		1/29/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/1/61		Mt Olivet Cemetery		Washington, D.C.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
W.K.Huntemann & Son. 5732 Georgia Ave N.W. D.C.		FEB 3 '61		Charles S. Petty			

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00113



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

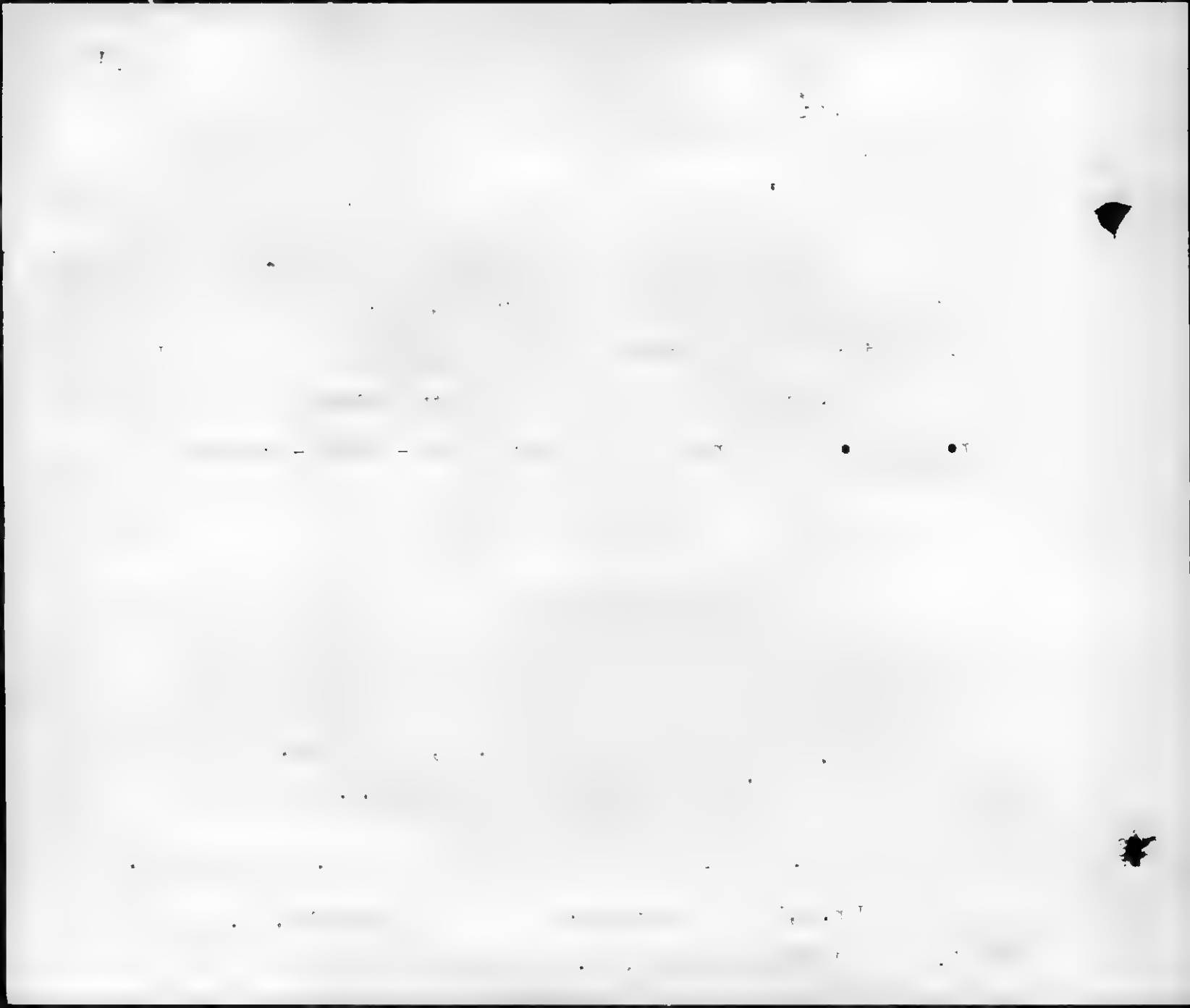
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

105

C0114

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS 33 Jefferson Place	
3. NAME OF DECEASED (Type or print) First Jenny Middle FINE Last DEATH		4. DATE Month January Day 11 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Hurwitz		14. MOTHER'S MAIDEN NAME Yetta (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr Julius Fine- Husband- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ovarian 175.0 DUE TO Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Resident attended the deceased from Nov. 26, 1960 , to Jan. 11, 1961 , that (I) (w) last saw the deceased alive on Jan. 10, 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE 1:15 A.M. 1/11/61	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 12, 1961	
23c. NAME OF CEMETERY OR CREMATORY Knoseth Israel		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR JAN 16 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



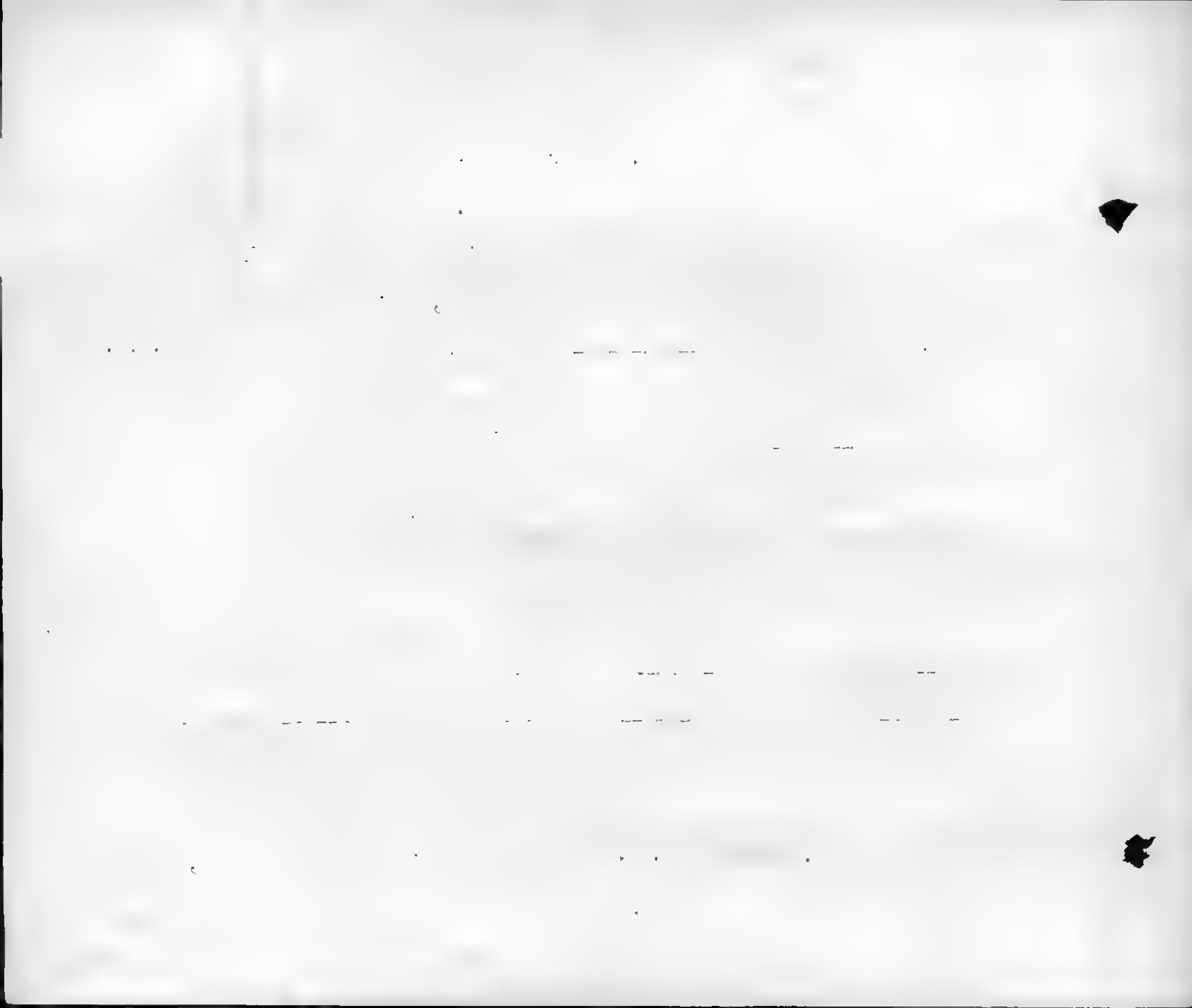
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

106

C0115

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	
c. LENGTH OF STAY IN 1b 9 mos. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Rt. # 1 Box 138	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Allen Last Finney		4. DATE OF DEATH Month 1 Day 11 Year 19 61	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bob Finney		14. MOTHER'S MAIDEN NAME Polly ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Chronic Brain Syndrome Associated with Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NON-MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24/ 1960 to 1/11/ 1961 , that (I) (we) last saw the deceased alive on 1/11/ 1961 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61	
23c. NAME OF CEMETERY OR CREMATORY St. James		23d. LOCATION (City, town, or county) (State) Shelltown, Somerset, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR JAN 19 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE [Signature]	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please inform the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

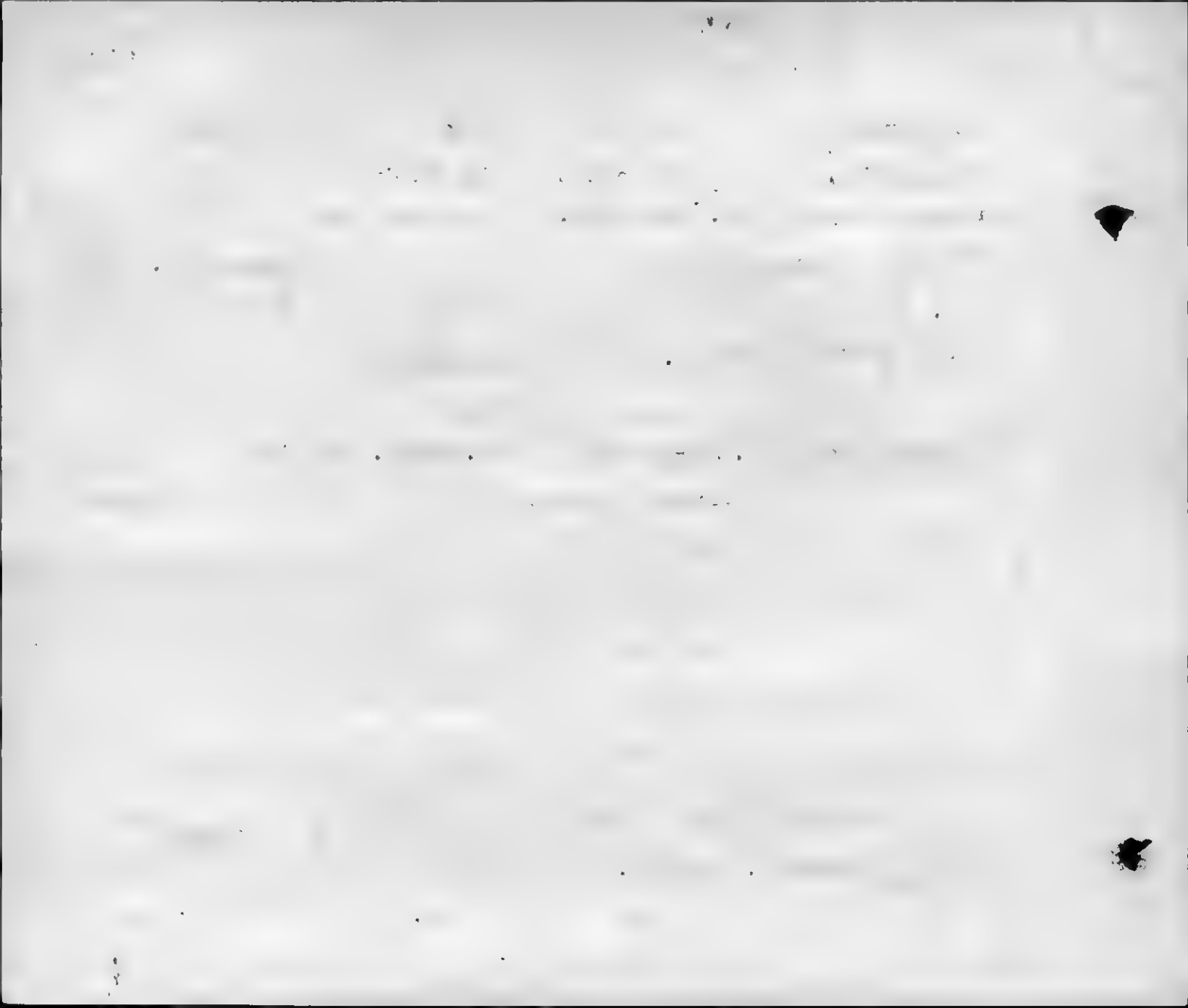
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00116

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Few seconds		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 7 Idlewood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Wessley Foy		4. DATE OF DEATH January 27th. 1961		5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/96		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman at Gildden Paint Co.		12. KIND OF BUSINESS OR INDUSTRY Pennsylvania		13. BIRTHPLACE (State or foreign country) USA		14. CITIZEN OF WHAT COUNTRY USA		15. FATHER'S NAME ?		16. MOTHER'S MAIDEN NAME ?		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes First World war.		18. SOCIAL SECURITY NO. 213-07-0768			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying 420.1 DUE TO lest.		20. INTERVAL BETWEEN ONSET AND DEATH Sudden		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 22f. (City or town) (County) (State)		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24. CHIEF MEDICAL EXAMINER Gustave H. Faubert M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		25. DATE SIGNED 1/27/61		26. ACTUAL SIGNATURE Gustave H. Faubert M.D.		27. EXAMINER'S NAME (Type) Gustave H. Faubert M.D.		28. ADDRESS (Street, city, town, or county) Baltimore Nat'l Cem. Baltimore, Md.	
29. BURIAL, CREMATION, REMOVAL (Specify) Burial		30. DATE THEREOF 1/30/61		31. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		32. LOCATION (City, town, or country) (State) Baltimore, Md.		33. FUNERAL DIRECTOR Hopping and Kirkley		34. ADDRESS Glen Burnie, Md.		35. REC'D BY REGISTRAR FEB 1 '61		36. REGISTRAR'S SIGNATURE Charles S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

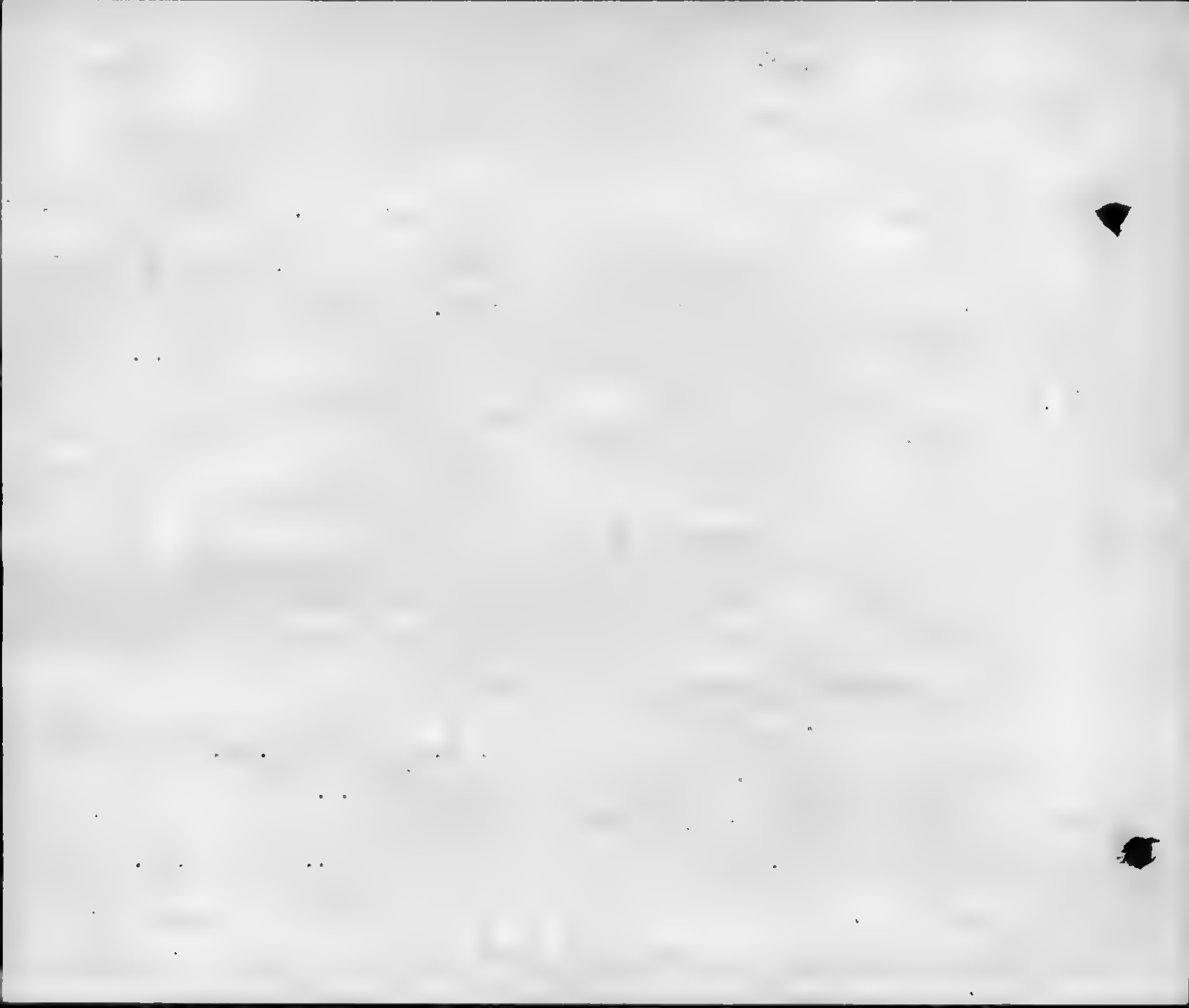
CERTIFICATE OF DEATH

108

C0084

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>14 Bancroft Ave., Bayridge</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Garfield</u> Middle <u>C.</u> Last <u>GAMBLE</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 23, 1884</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofing</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>England</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Patience J.J. McKenna #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> DUE TO (b) <u>Fall down flight of stairs</u> (c) <u>possibly associated cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Spinal osteoarthritis & generalized arteriosclerosis</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>was notified</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>fall down stairs</u>	
20c. TIME OF INJURY Month <u>Jan</u> Day <u>21</u> Year <u>1961</u> Hour a.m. <u>4:05</u> p.m. <u>1:30</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Annapolis</u> (County) <u>AA</u> (State) <u>MD</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 21. I certify that (I) <u>Harold R. Bohlman</u> attended the deceased from <u>Jan 18, 1961</u> to <u>Jan 21, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>Jan 21, 1961</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Harold R. Bohlman</u> M.D. 22b. DATE SIGNED <u>1/24/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Harold R. Bohlman</u> 22d. ADDRESS <u>98 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 23b. DATE THEREOF <u>1/24/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> 23d. LOCATION (City, town or county) <u>Prince George Co.</u> (State) <u>MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyons & Sons</u> 25a. REC'D BY REGISTRAR <u>25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

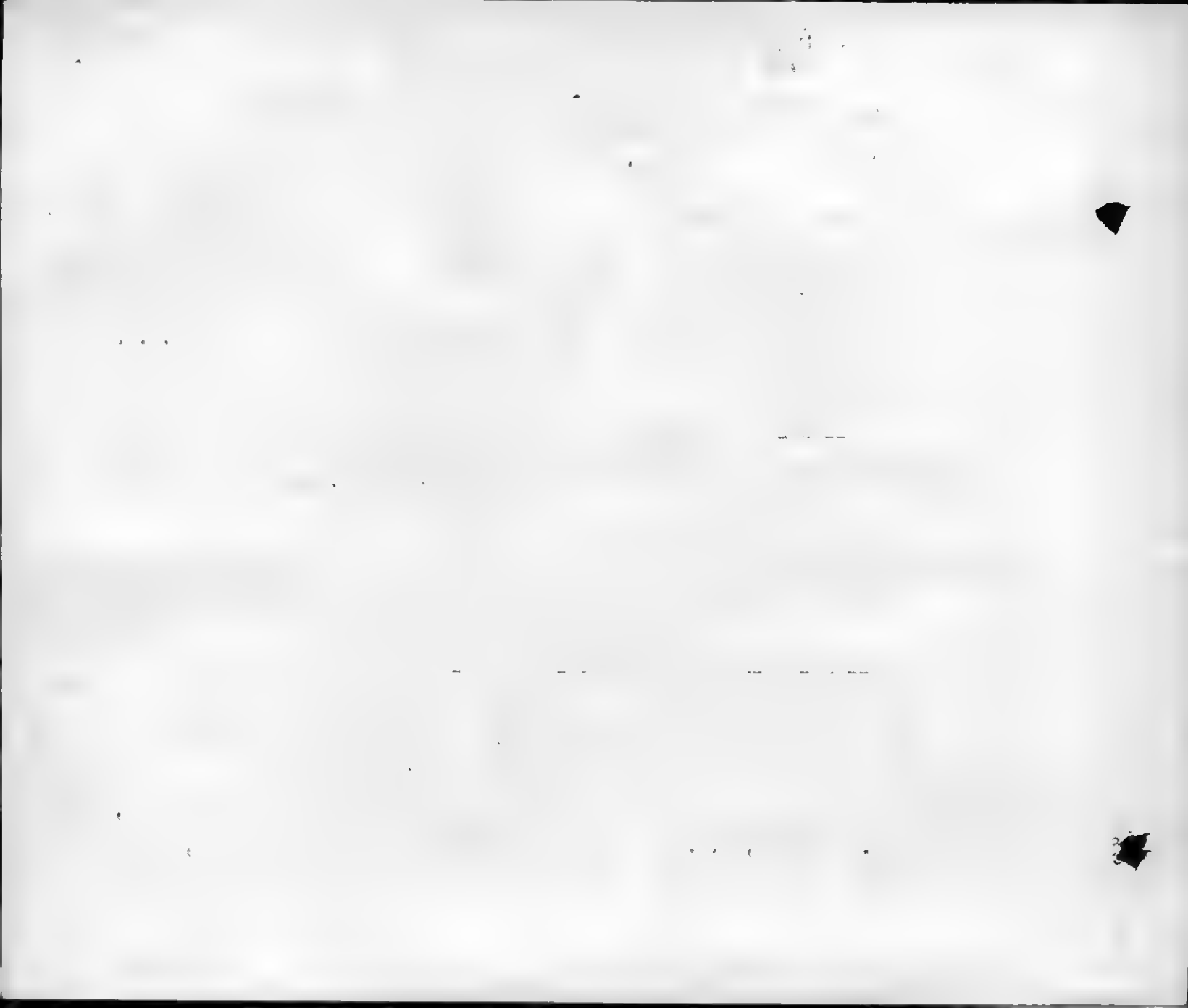
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

109

CERTIFICATE OF DEATH

60117

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF RESIDENCE (If not in hospital, give street address) 9 mos. 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Unknown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mark Middle Garrett Last Garrett		4. DATE OF DEATH Month 1 Day 1 Year 19 61	
5 SEX Male	6. COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1891
9 AGE (In years at birthday) 70		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10	IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min 10
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Coachman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME James Garrett	
14 MOTHER'S MAIDEN NAME Mary Posey		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) 422.1		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY DEATH EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1/20 p. m. 1/1		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1/20 (County) 1/1 (State) 61	
21 I certify that (I) (this hospital) attended the deceased from 1/1/61 to 1/1/61 , that (I) (we) last saw the deceased alive on 1/1/61 , and that death occurred at 5:30 AM , from the causes and on the date stated above			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE January 3, 1961	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-1-61		23b. DATE THEREOF 5-1-61	
23c. NAME OF CEMETERY OR CREMATORY University of Md		23d. LOCATION (City, town, or county) Balt. Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Reese Mortuary		25a. REC'D BY REGISTRAR Anna, Md	
25b. REGISTRAR'S SIGNATURE Anna, Md		25c. DATE JAN 6 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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110

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0118

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Rt-1, Box-406F		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle N. Last GASS				4. DATE OF DEATH Month January Day 12 Year 19 61			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 31, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY N. S. Gun Factory		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JAMES F. GASS				14. MOTHER'S MAIDEN NAME SARAH EAGEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Lydia M. Gass Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crunchogenic Carcinoma with metastases 62.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan. 1, 1961 to Jan. 11, 1961 that (I) (we) last saw the deceased alive on Jan. 11, 1961 , and that death occurred at 6:20 A.M. from the causes and on the date stated above							
22a. SIGNATURE Richard N. Peeler				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/12/61	
22c. PHYSICIAN'S NAME (Type) RICHARD N. PEELER				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, or Removal (Specify)		23b. DATE THEREOF 1-14-1961		23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial		23d. LOCATION (City, town, or county) (State) Mayo A.C. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				25a. REC'D BY REGISTRAR AN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

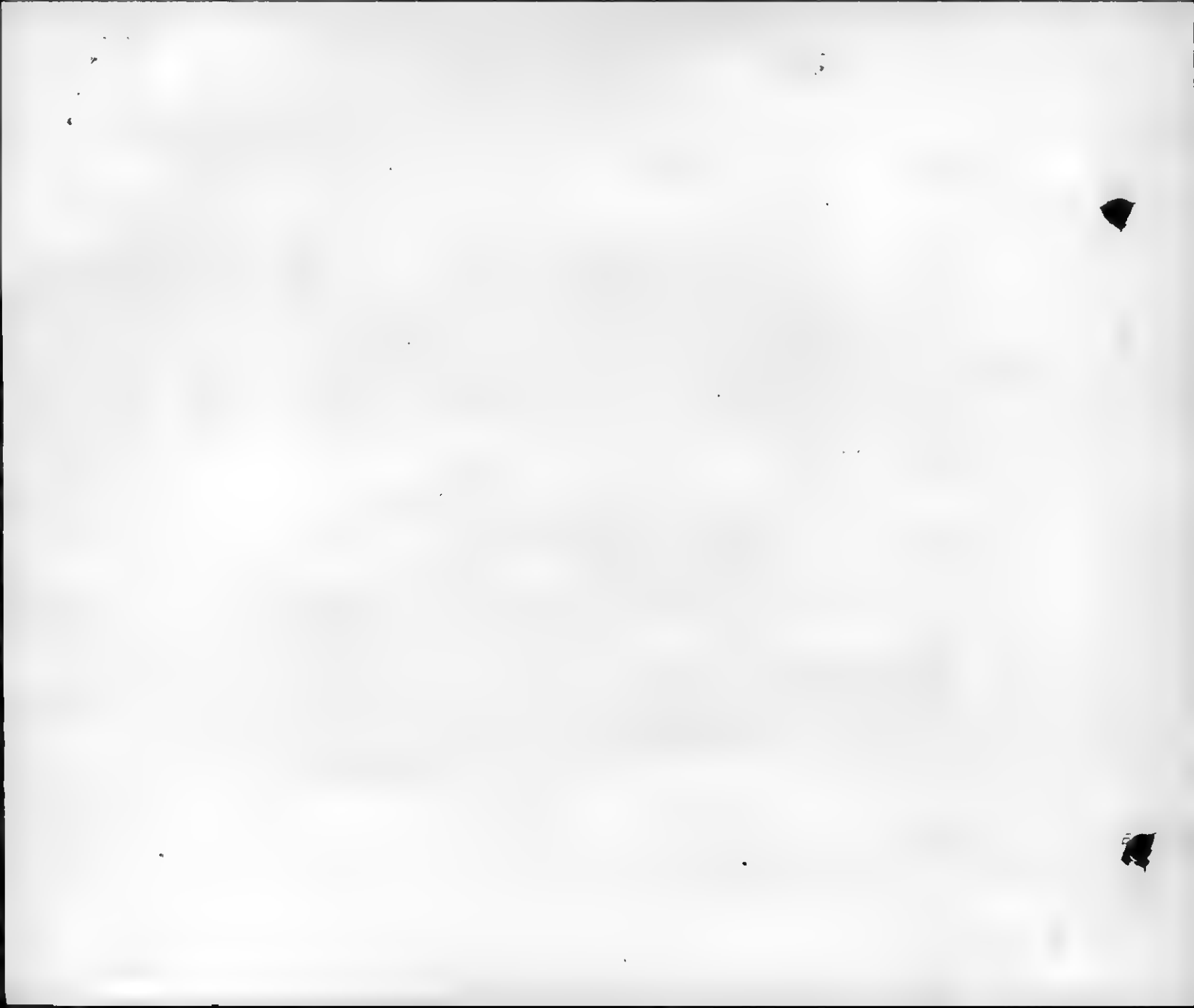


may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00119

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradise (Lake Shore)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen'l. Hosp.</u>		d. STREET ADDRESS <u>Rt. 10</u>	
3. NAME OF DECEASED (Type or print) <u>Elwyn E. Giddings</u>		4. DATE OF DEATH <u>January 6 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5th July 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker (K-7)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.J. McGrath Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Giddings</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Goodman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>27-05-9703</u>	
17. INFORMANT <u>Mrs. Lottie Giddings</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Ch. Bronchitis</u> OR (c) <u>acute Left pyelitis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>1 day.</u> <u>?</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Internal Hydrocephalus c/a.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-61</u> to <u>1-6-61</u> , that (I) (we) last saw the deceased alive on <u>1-6-61</u> , and that death occurred at <u>7:30 pm</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Skipley</u> M.D.		22b. DATE SIGNED <u>1-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Skipley</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10th Jan 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>	23d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 12 '61</u>	



may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

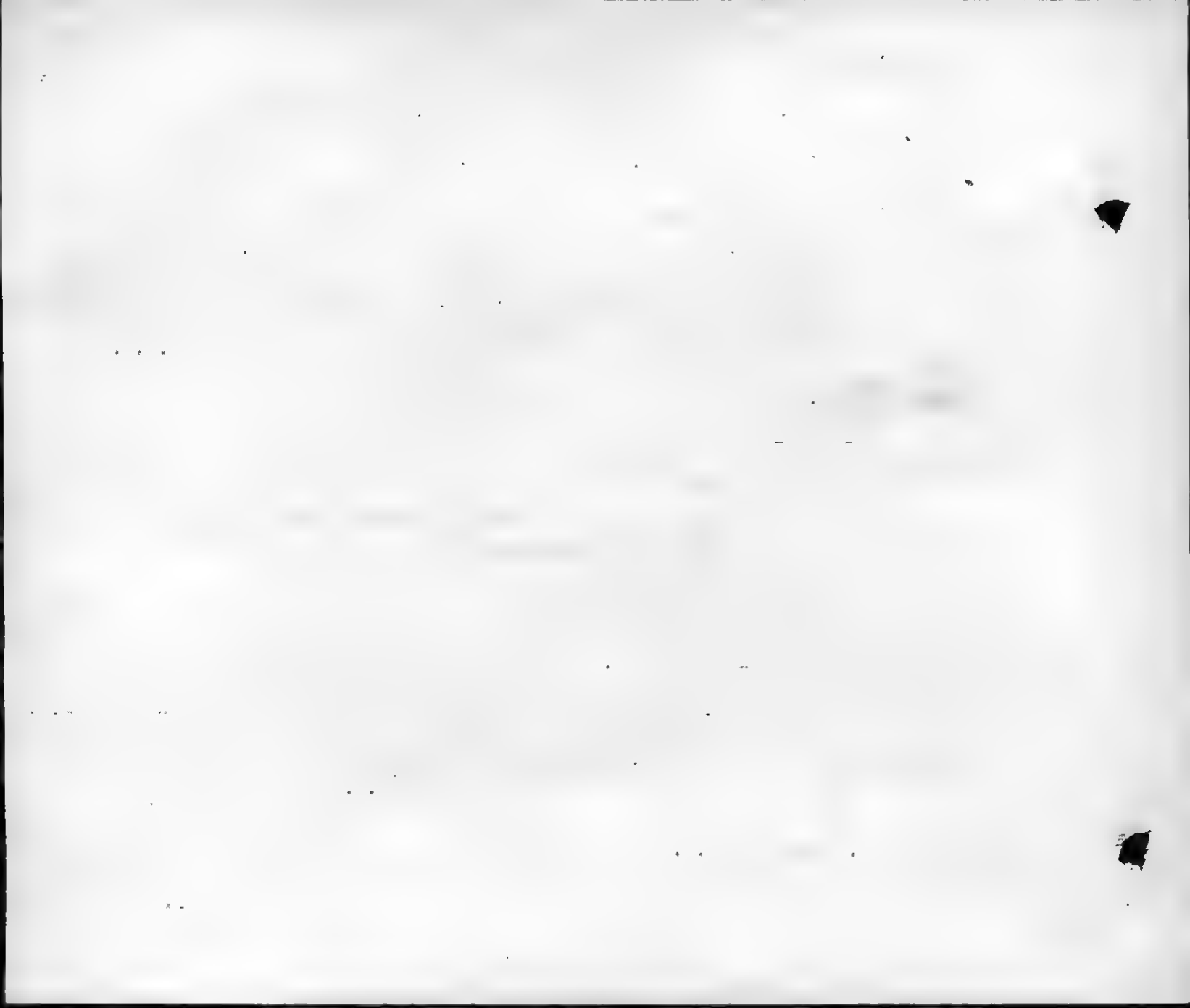
CERTIFICATE OF DEATH

112

Items 8, 9 Film 6279 1-16-61 st

00120

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8 years 9 mos. 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 333 Canon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Fannie Middle Gland Last Gland		4 DATE OF DEATH Month 1 Day 8 Year 1961	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 18/1867 1896
9 AGE (In years last birthday) 66 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Unknown
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Mitchell		14 MOTHER'S MAIDEN NAME Fannie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Chronic Brain Syndrome associated with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year How - 11 - 19 p. m.	20d INJURY OCCURRED While - 11 - 19 at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/12/1954 to 1/8/1961 , that (I) (we) last saw the deceased alive on 1/8/1961 and that death occurred at 10:05 from the causes and on the date stated above			
22a SIGNATURE L. Benedict, M.D.		22b DATE SIGNED 1/9/61	
22c PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d ADDRESS Crownsville State Hospital, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1/14/61	23c NAME OF CEMETERY OR CREMATORY St. James Cemetery	23d LOCATION (City, town, or county) (State) Chestertown, Md.
24 FUNERAL DIRECTOR'S SIGNATURE Signatures		25a. REC'D BY REGISTRAR JAN 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



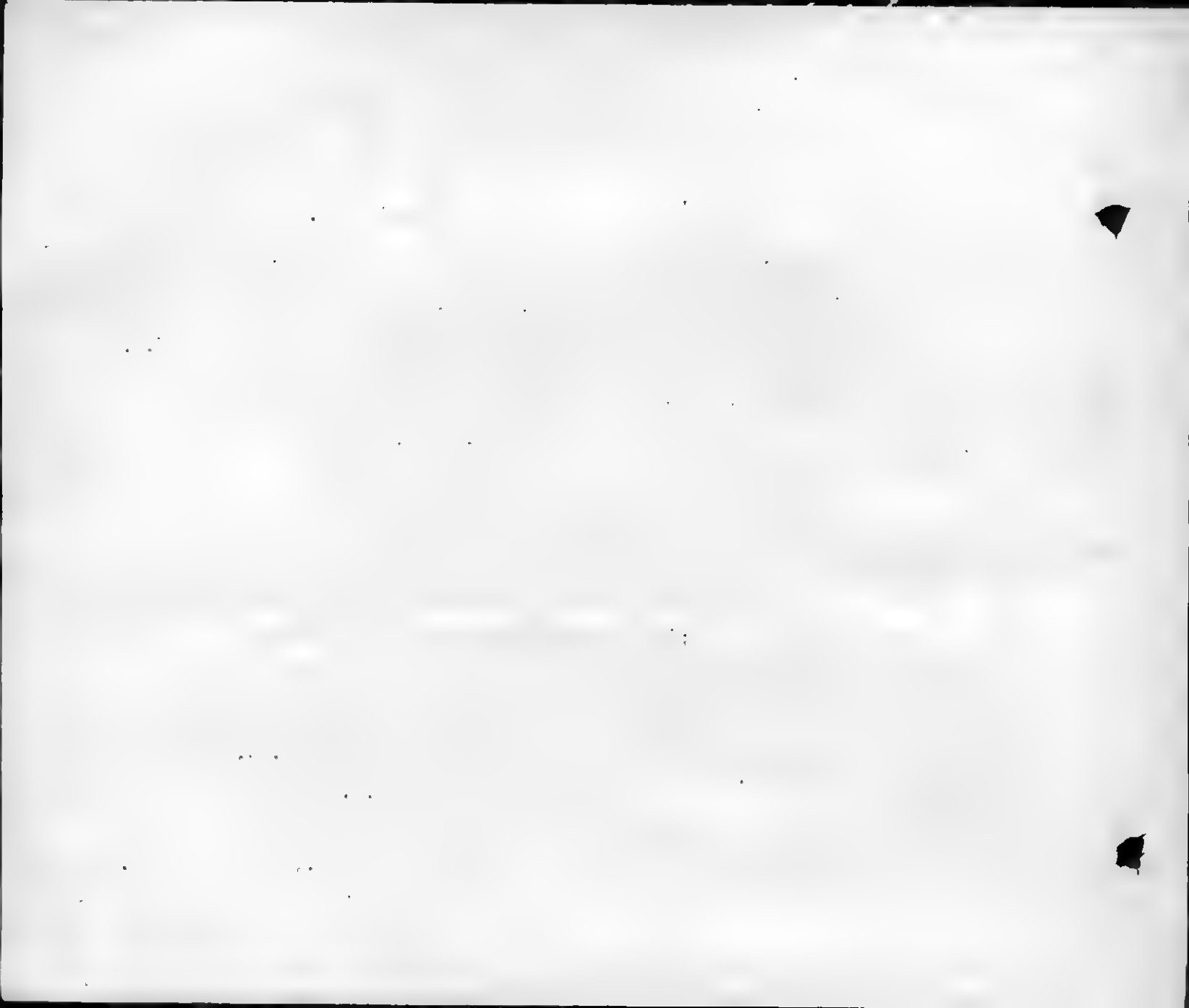
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

113

00121

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival). Anne Arundel General Hospital			d. STREET ADDRESS 605 Burnside St.		
3. NAME OF DECEASED (Type or print) First Ella Middle B Last GORRELL			4. DATE OF DEATH Month January Day 3 Year 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1896		9. AGE (In years last birthday) 64 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME OLAF KLAKRING		
14. MOTHER'S MAIDEN NAME LOUISA JAMES			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MR IRA L. GORRELL #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1/2 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, bilateral nephroethiasis					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ANNAPOILIS	(County) MD	(State)
21. I certify that (I) (the hospital) attended the deceased from May 19 57 to Jan. 3, 1961 , that (I) (we) last saw the deceased alive on Jan. 3, 1961 , and that death occurred at 11:00 A.M. M, from the causes and on the date stated above.					
22a. SIGNATURE Samuel Borssuck		22b. DATE SIGNED 11:00 A.M.		22c. PHYSICIAN'S NAME (Type) Samuel Borssuck	
22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	23b. DATE THEREOF 1-5-1961	23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEM.	23d. LOCATION (City, town, or county) ANNAPOILIS	(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SONS		ADDRESS ANNAPOLIS MD		25a. REC'D BY REGISTRAR JAN 6 61	25b. REGISTRAR'S SIGNATURE William S. Frank



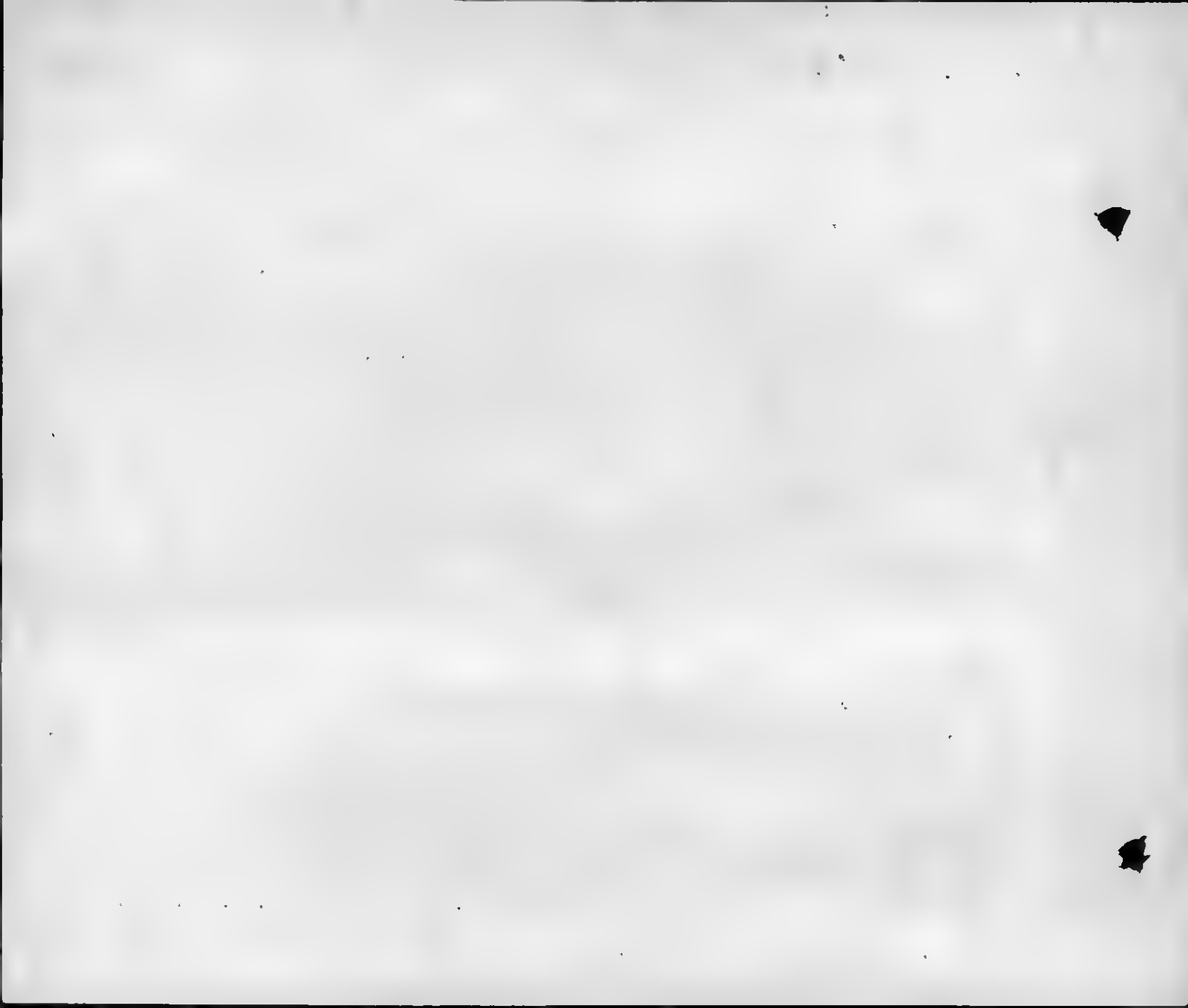
1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
60122											
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>MD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Old Mill Rd.</u>						c. LENGTH OF STAY IN IL <u>21 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Mill Rd.</u>						d. STREET ADDRESS <u>Same</u>					
3. NAME OF DECEASED (Type or print) <u>Ernest Green</u>						4. DATE OF DEATH <u>Jan 27/61</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>3/20/54</u>		9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Ernest Green</u>						14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Parents.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Suffocation by smoke</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>1/27/61</u> Hour a.m. <u>11</u> p.m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Pasadena</u>				20g. (County) <u>MD</u>				20h. (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Ernest W. Rouben</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Ernest W. Rouben</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>1-27-61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>						22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>					
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore, 30, Md.</u>						24a. REC'D BY REGISTRAR <u>JAN 27 '61</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Rouben</u>					



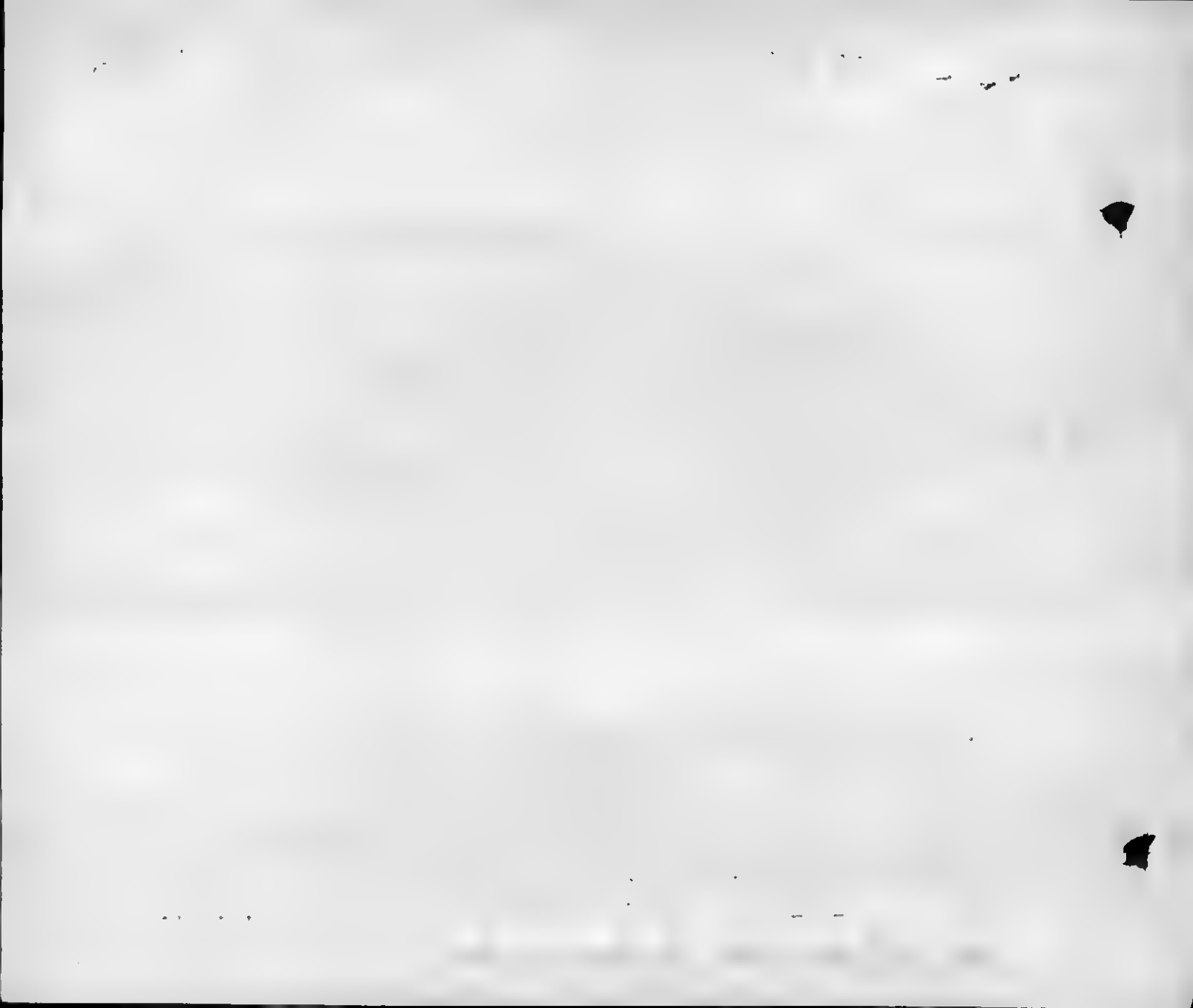
1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any vessel within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>anne arundel</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Santo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>1 Same</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>						c. LENGTH OF STAY IN 1b <u>1 1/2 year</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 Hill Rd.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ernest Green</u>						4. DATE OF DEATH <u>1/22/61</u>					
5. SEX <u>C</u>						6. COLOR OR RACE <u>C</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>4/15/28</u>					
9. AGE (in years last birthday) <u>32</u> yrs.						10. F UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u></u>					
11. BIRTHPLACE (State or foreign country) <u></u>						12. CITIZEN OF WHAT COUNTRY? <u></u>					
13. FATHER'S NAME <u>Ernest Green</u>						14. MOTHER'S MAIDEN NAME <u>Laura White</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u></u>						16. SOCIAL SECURITY NO. <u></u>					
17. INFORMANT <u>Dr. J. R. R. (b. t. r.)</u>						Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u>											
(b) <u>916.0</u> DUE TO											
(c) <u></u> DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped on the second floor of a house that burned down.</u>					
20c. TIME OF INJURY Month, Day, Year <u>1/22/61</u> 19 <u>1:30</u> a.m. <u></u> p.m.						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> Other <u></u>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>						20f. (City or town) <u></u> (County) <u></u> (State) <u></u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Custome 18 Bankhead</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Custome 18 Bankhead</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>I-27-61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Church Ct</u>						22d. LOCATION (City, town, or country) (State) <u>Magothy A. A. Co., Md</u>					
23. FUNERAL DIRECTOR <u>Frank L. Pennington</u>						24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>					
ADDRESS <u>Baltimore 30, Md</u>						DATE <u>JAN 27 '61</u>					



FOR STATE
HEALTH DEPT.

TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director or to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

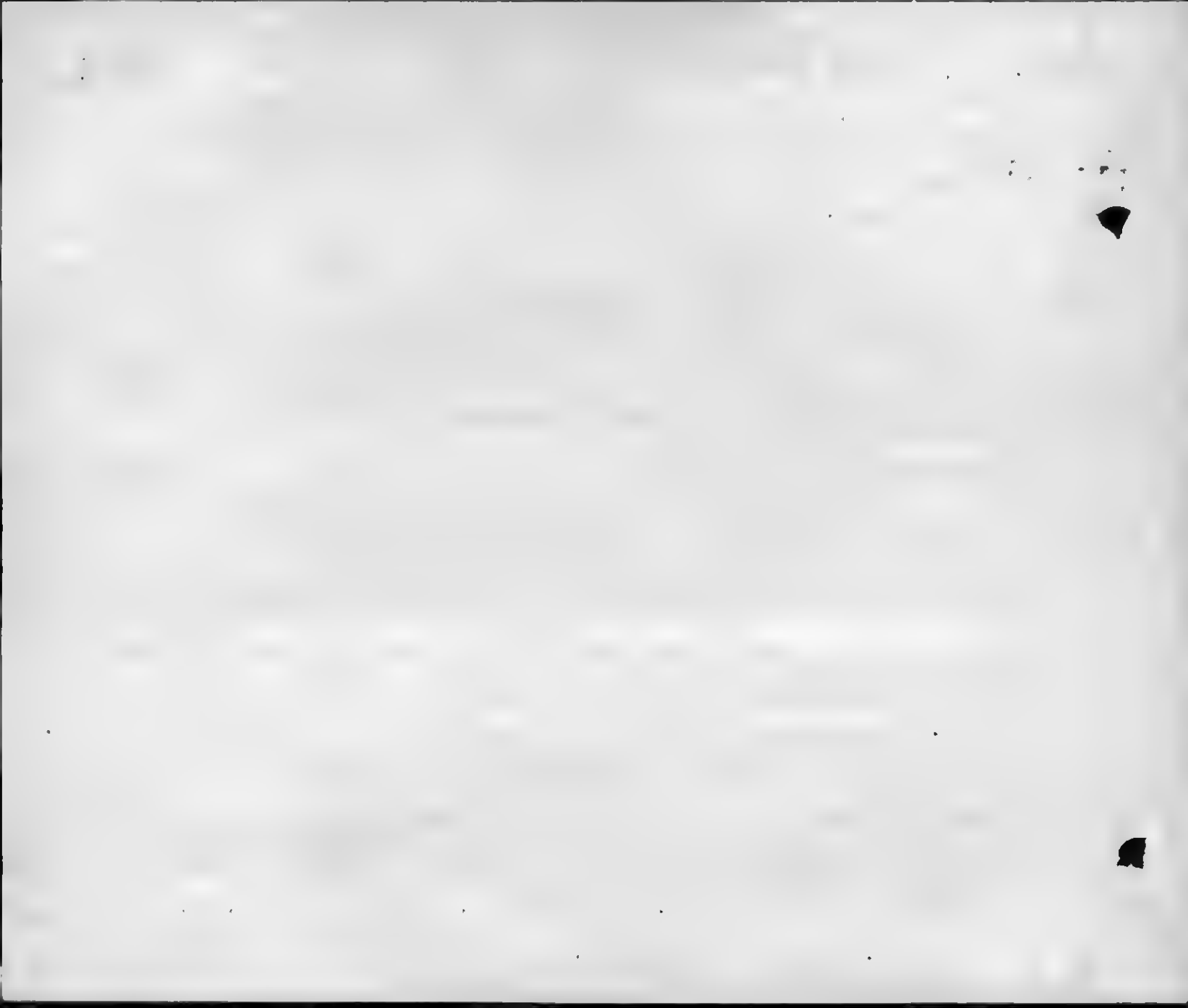
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60085

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN life Life		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Darnell Avery Green		First		Middle		Last		4. DATE OF DEATH 1/22/61		Month		Day		Year 19	
5. SEX Male		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/60		9. AGE (In years last birthday) 1 yr.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours M n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore City Md		12. CITIZEN OF WHAT COUNTRY? U									
13. FATHER'S NAME Ernest Green		14. MOTHER'S MAIDEN NAME Dolores Parker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT The Parents		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7/1x00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 100 hr			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Falls from second floor of home while in bathroom.													
20c. TIME OF INJURY Hour m. 11:34 m. Month, Day, Year 1/22/61 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Pasadena		(County) Anne Arundel		(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Isaiah L. Brown		EXAMINER'S NAME (Type) Isaiah L. Brown		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/23/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cem.		22d. LOCATION (City, town, or country) Magothy, A. E. Co., Md.		(State) Md.							
23. FUNERAL DIRECTOR Isaiah L. Brown, Baltimore 30, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 27 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

1099279XV5



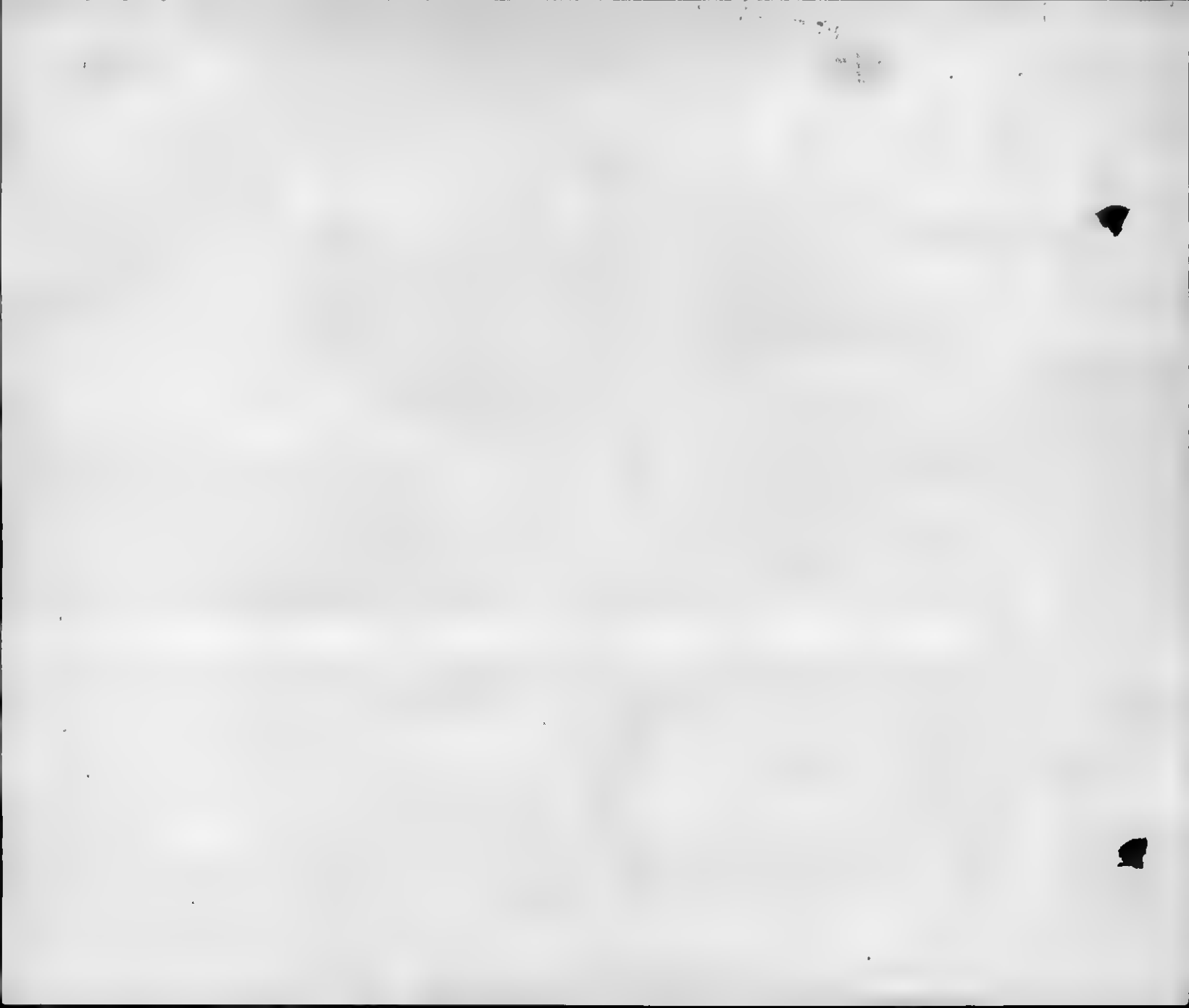
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 4M3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00124									
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if inst fullon: Residence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>JOHNS HOPKINS</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNS HOPKINS</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNS HOPKINS</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>JOHNS HOPKINS</u>					d. STREET ADDRESS <u>JOHNS HOPKINS</u>				
3. NAME OF DECEASED (Type or print) <u>Jeweline Cynthia Green</u>					4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1961</u>				
5. SEX <u>F</u>					6. DATE OF BIRTH Month <u>1</u> Day <u>22</u> Year <u>1961</u>				
6. COLOR OR RACE <u>C</u>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				
11. BIRTHPLACE (State or foreign country) <u>JOHNS HOPKINS</u>					12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>				
13. FATHER'S NAME <u>Ernest Green</u>					14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>JOHNS HOPKINS</u>					Address <u>JOHNS HOPKINS</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>suffocation by smoke</u>									
DUE TO (b) <u>None</u>									
DUE TO (c) <u>None</u>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>									
20c. TIME OF INJURY Month, Day, Year <u>1 Hour a.m. - 1/22/1961</u>									
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>JOHNS HOPKINS</u>									
20f. (City or town) (County) (State) <u>JOHNS HOPKINS</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Isaiah L. Brown</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Isaiah L. Brown</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22b. DATE THEREOF <u>1-27-61</u>					Address (Street, city, town, or county) <u>JOHNS HOPKINS</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>					22d. LOCATION (City, town, or country) (State) <u>Magothy, A.A. Co., Md.</u>				
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>					24a. REC'D BY REGISTRAR <u>JAN 27 1961</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>				



FOR STATE HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit pass if it is filed with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

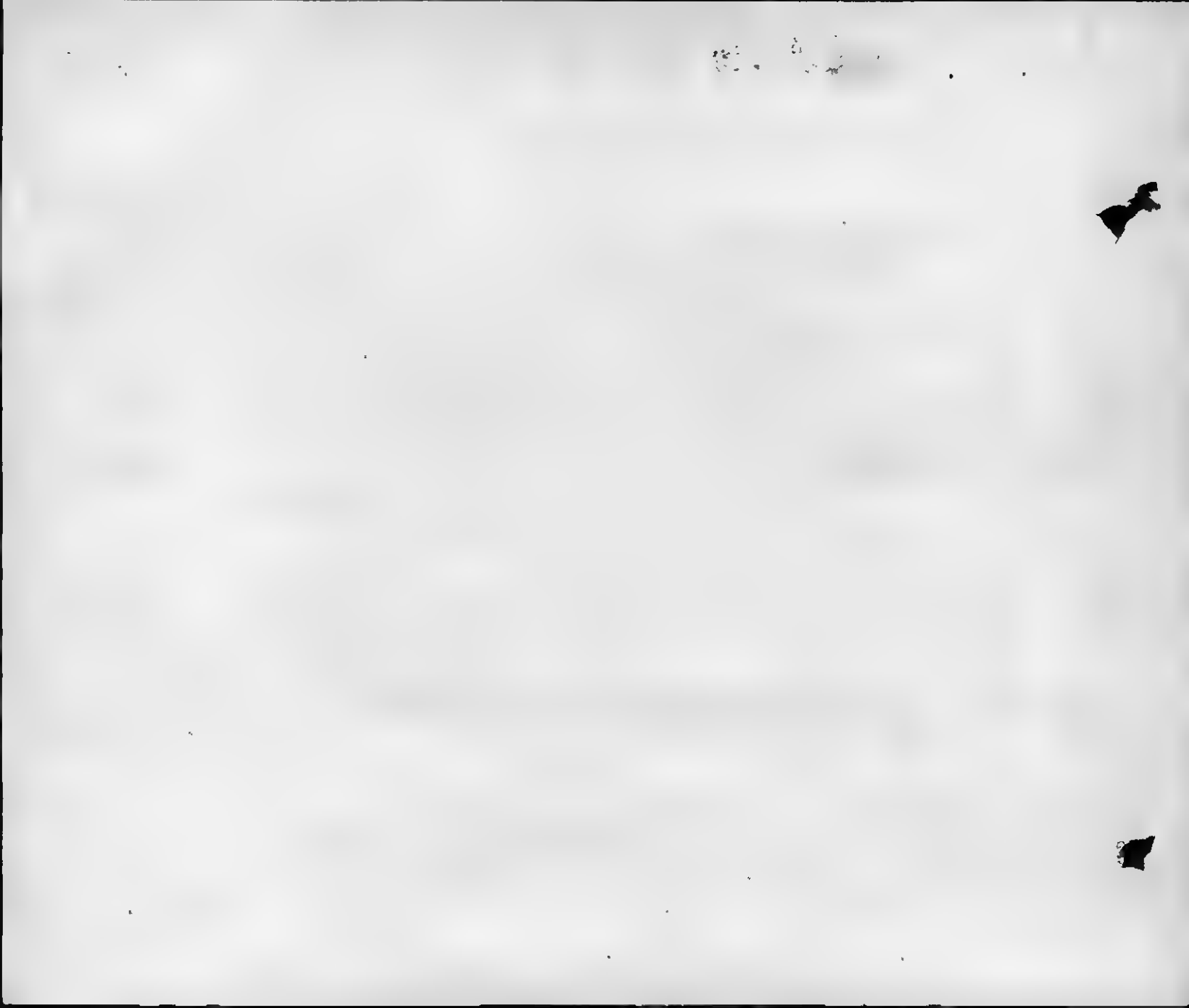
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00125

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN IT <u>30</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>2400</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marion Allison Green</u> First Middle Last		4. DATE OF DEATH <u>1/22/61</u> Month Day Year		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/3/54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Ernest Green</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Parents</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto traffic accident</u> 20c. TIME OF INJURY Month, Day, Year <u>11/44 p.m. 1/22/61</u> 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Pasadena</u> (County) <u>A.A.</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gustave J. Valentini</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gustave J. Valentini</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/22/61</u> DATE SIGNED Address (Street, city, town, or county) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 27 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Isaiah L. Brown</u>			

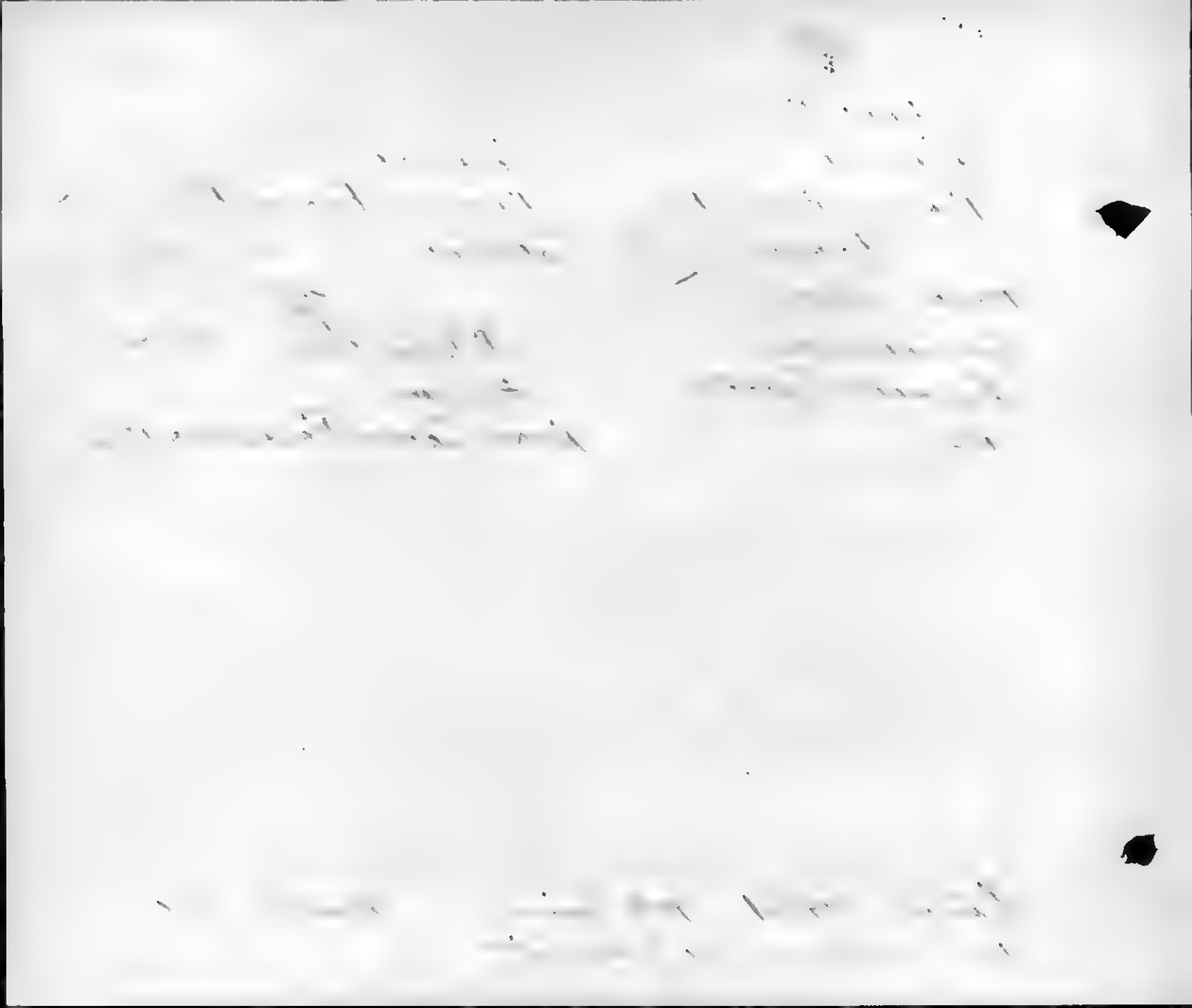


MARYLAND STATE DEPARTMENT OF HEALTH
119 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00126

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY U. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. LENGTH OF STAY IN 1b PASADENA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BAYSIDE BEACH Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle R Last GREEN				4. DATE OF DEATH Month 1 Day 10 Year 1961			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 75 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GEN. LABORER		10b. KIND OF BUSINESS OR INDUSTRY P.A. Co. MD		11. BIRTHPLACE (State or foreign country) PA. Co. MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD GREEN				14. MOTHER'S MAIDEN NAME FLIZA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT ANNIE GREEN PASADENA MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 2, 1960 to Jan. 10, 1961 , that (I) (we) last saw the deceased alive on June 9, 1961 , and that death occurred at 12 P.M. from the causes and on the date stated above							
22a. SIGNATURE R. M. McLaughlin				22b. DATE SIGNED 1/10/61		22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin	
				22d. ADDRESS 3708 Mount Airy Rd Pasadena, Md			
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1/14/61		MA Zion		Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays				25a. REC'D BY REGISTRAR 638 N. Calver St		25b. REGISTRAR'S SIGNATURE James E. Hays	
				DATE JAN 13 '61			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

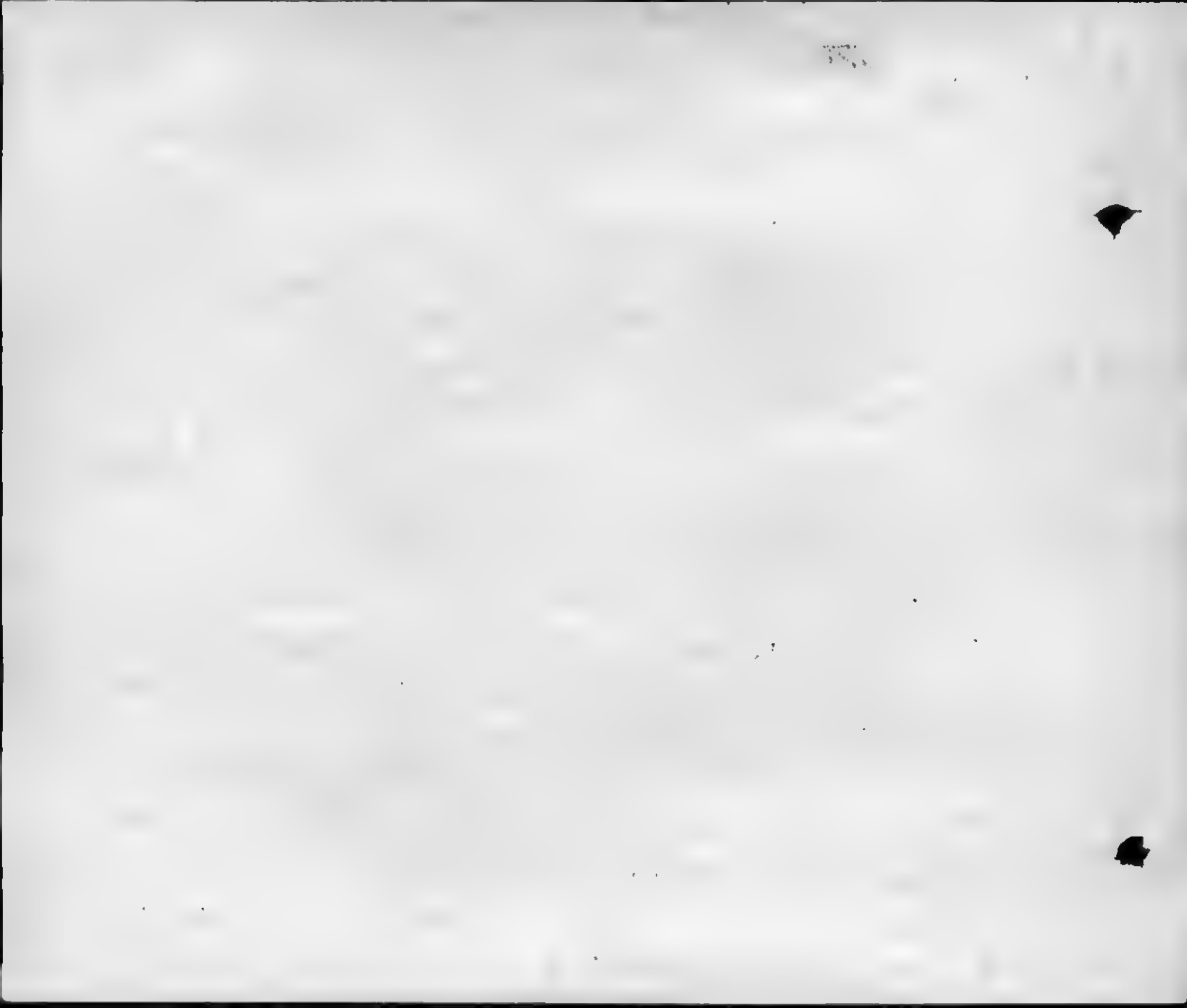
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60127

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pagoada</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1177 Old</u>		2. USUAL RESIDENCE (Where deceased lived, if not before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> d. STREET ADDRESS <u>1177 Old</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annika L. Crer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Robert Green</u>		14. MOTHER'S MAIDEN NAME <u>Delores Crer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		17. INFORMANT <u>Mr. Crer</u> Address <u>1177 Old</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> 7/16.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Was trapped in second floor of home which was destroyed by fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/16/61</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Pagoada</u> (County) <u>MD</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Eustace H. Bachmader</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Eustace H. Bachmader</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) <u>Magothy, A.A. Co., Md.</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 27 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

MEDICAL CERTIFICATION



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
C0128									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>None</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 years</u>					c. LENGTH OF STAY IN 1b <u>21 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oldmill Rd.</u>					d. STREET ADDRESS <u>Same</u>				
3. NAME OF DECEASED (Type or print) <u>Ernest Green</u>					4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>19</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/21/56</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Ernest Green</u>					14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The P. ...</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u>									
DUE TO (b) <u>9/16/61</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>None</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>11/20 p.m. 1/22/61 19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2nd floor of home</u>					20f. (City or town) (County) (State) <u>Pasadena Md</u>				
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave M. Faubert</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave M. Faubert, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/23/61</u>				
					Address (Street, city, town, or county) (State)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>			
23. FUNERAL DIRECTOR ADDRESS <u>Isaian L. Brown, Baltimore 30, Md.</u>					24a. REC'D BY REGISTRAR <u>DAIAN 2 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. ...</u>		

100
100
100
100



122

CERTIFICATE OF DEATH

C0129

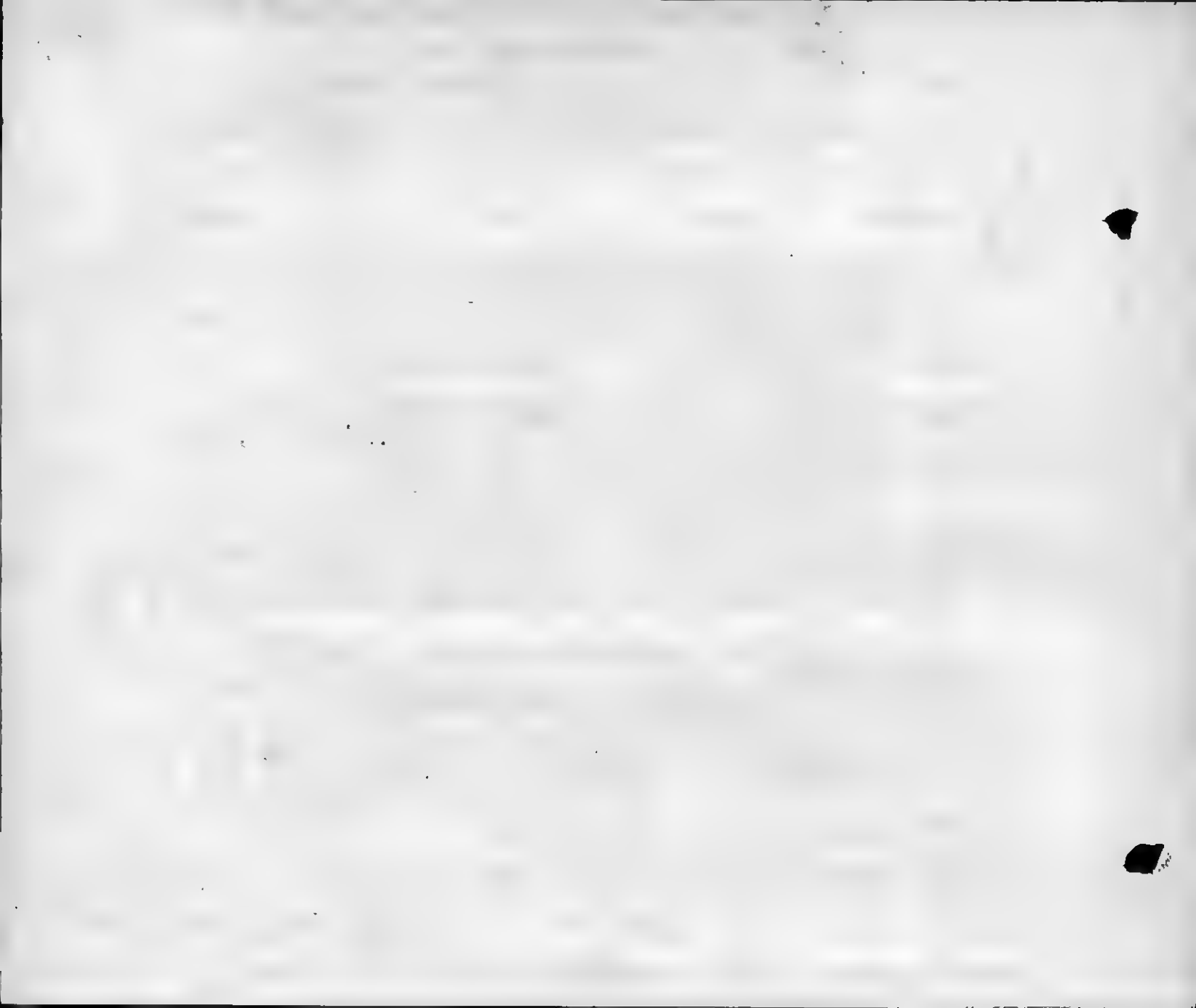
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANN. ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, ANNAPOLIS, MARYLAND				d. STREET ADDRESS 635 CHASE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle (n) Last HAMMERBERG				4. DATE OF DEATH Month JANUARY Day 3rd Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-98		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SWEDEN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter HAMMERBERG				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I and II		17. INFORMANT Elizabeth H. Hammerberg (W) 635 Chase Ave., Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Disorder, Functional 1-3-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-25-60 , 19 60 , to 1-3 , 19 61 , that I last saw the deceased alive on 1-3-61 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Sylvan Busch M.D.				PHYSICIAN'S NAME (Type) Sylvan (n) BUSCH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-1961		22c. NAME OF CEMETERY OR CREMATORY Annapolis National		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor				24a. REC'D BY REGISTRAR DATE JAN 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AN</u>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. D. General Hospital</u>		d. STREET ADDRESS <u>85 N. West St.</u>	
3. NAME OF DECEASED (Type or print) <u>First Evelyn Middle Harris Last</u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1898</u> 62 yrs.
9. AGE (In years (add birth date))		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>	11. IF UNDER 24 HRS Hours <u>14</u> M. n. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. D. Hosp.</u>	
11. BIRTH PLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Boyd Covat</u>		14. MOTHER'S MAIDEN NAME <u>Lenora McFadden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>507-141-417</u>	
17. INFORMANT <u>Anne Harris</u>		Address <u>507-141-417</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost (c) _____ DUE TO _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>1-3-61</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-8-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>	22d. LOCATION (City, town or county) (State) <u>Besgate Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24a. REC'D BY REGISTRAR <u>Jan 9 61</u>	
24b. REGISTRAR'S SIGNATURE <u>W. S. Kravitz</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

203

60266

1. NAME OF DECEASED
(Type or Print)

Elsie N. Butler

2. DATE OF DEATH

Jan. 7, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore
721 Register Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE
Md.

B. COUNTY

Balto.

C. CITY OR TOWN

Baltimore

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

721 Register Ave.

(If rural, give location)

5. SEX

Female White

6. COLOR or RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Jan. 14, 1899

9. AGE (In years
last birthday)

61

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

George W. Butler 721 Register Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Myocarditis

?

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐

NO ☐

22. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1960 to Jan. 7, 1961 that (I) (we) last saw the deceased alive on Jan. 5, 1961 and that in (my) (our) opinion death occurred at 7 P.M., from the causes and on the date stated above.

23a. SIGNATURE

Needles

23b. ADDRESS

846 W. 36th St.

23c. DATE SIGNED

Jan. 9, 1961

24a. BURIAL, CREMATION,
REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

(City, town, or county)

(State)

Burial

Jan. 10, 1961

Evergreen Mem. Park

Finksburg Md.

25a. DATE REC'D BY HEALTH DEPT.

25b. NAME OF REGISTRAR

25c. FUNERAL DIRECTOR

ADDRESS

JAN 9 1961

Paul E. Chanoweth Jr.

3617 Chestnut Ave

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician and the funeral director must be present at the time of signing. The funeral director must be present at the time of signing. The funeral director must be present at the time of signing. The funeral director must be present at the time of signing.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

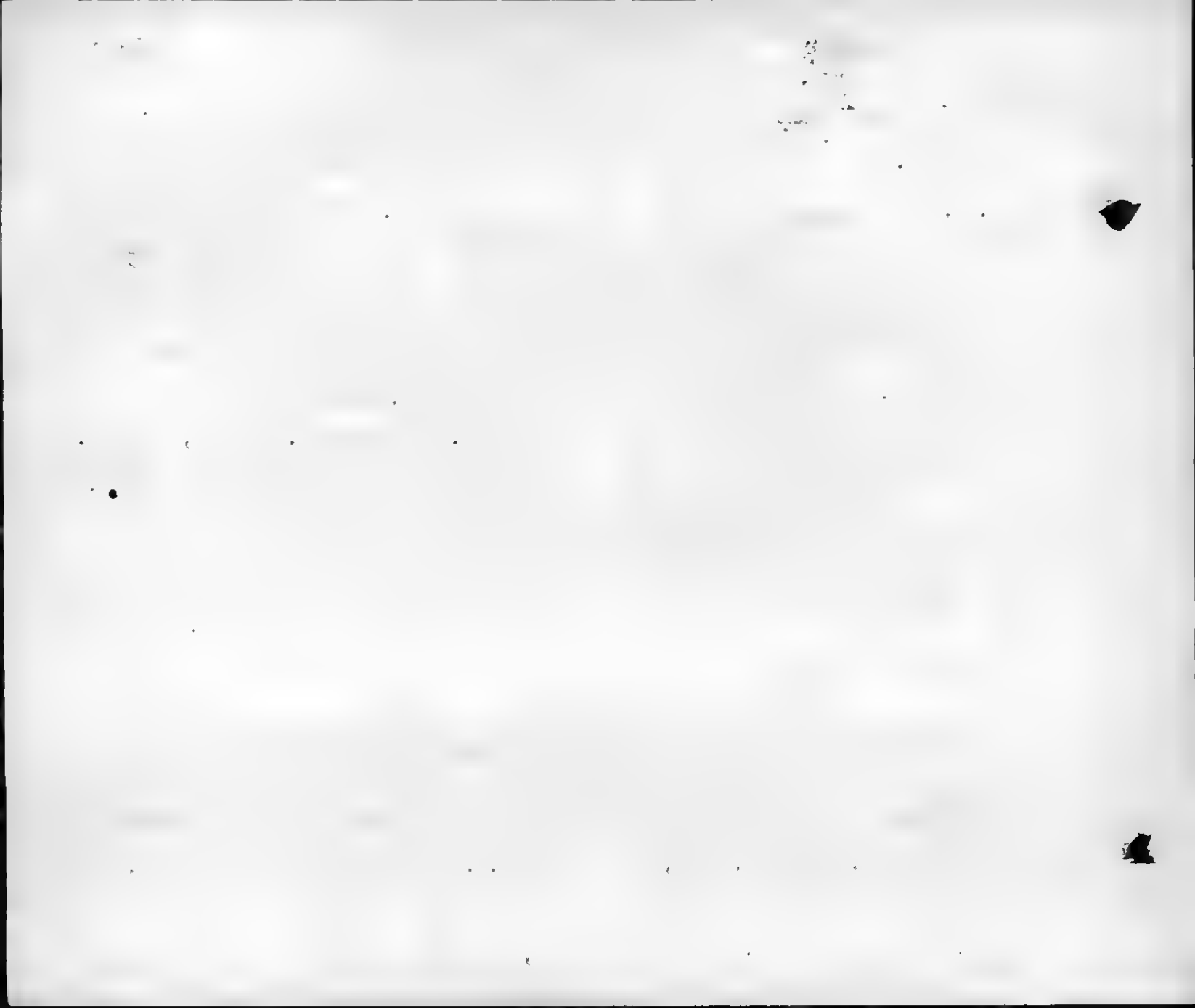
VR A15 (4)
15M 9/59

124

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00086

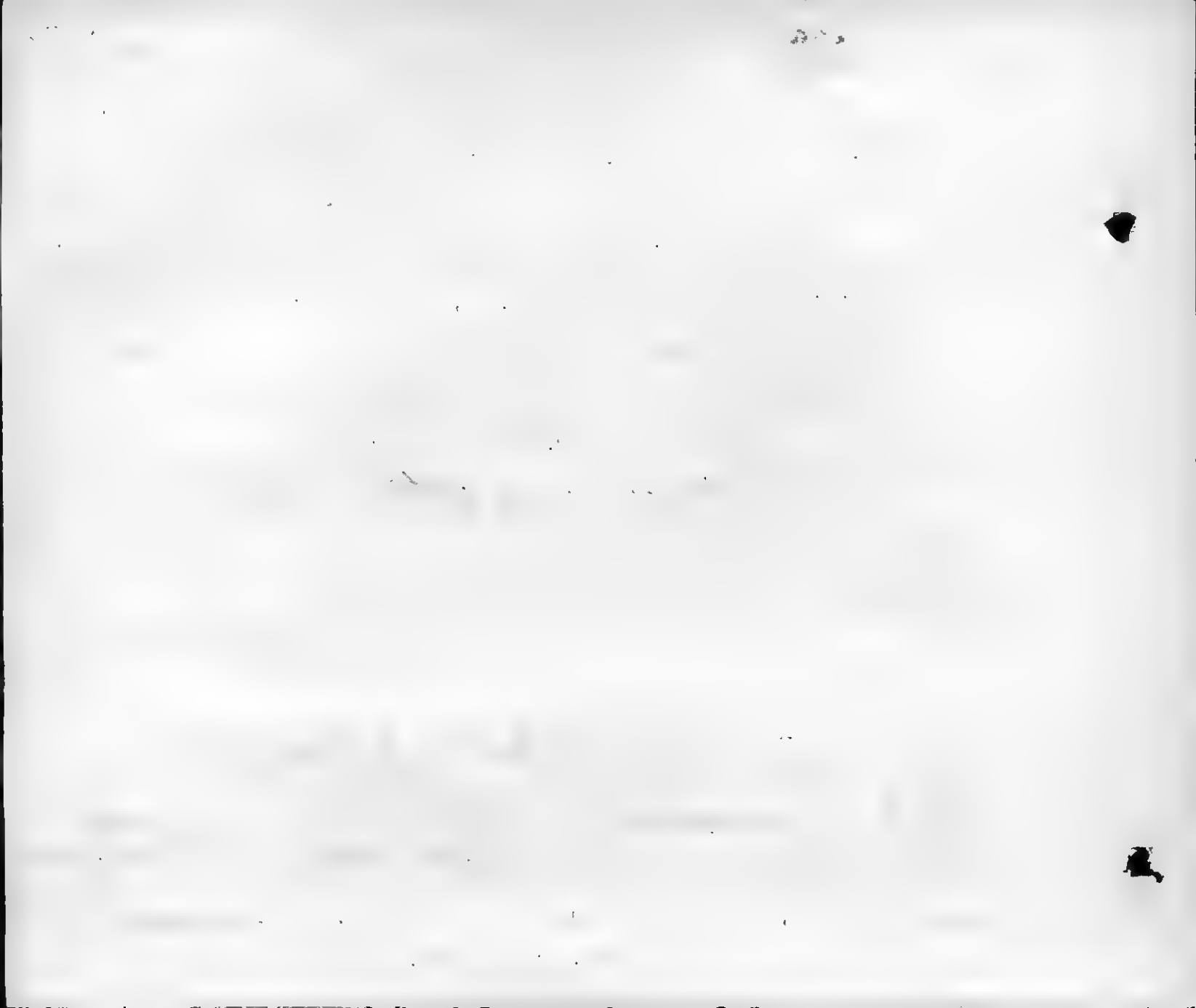
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS 7012 E. Baker Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHRISTOPHER Middle HILL Last HILL		4. DATE OF DEATH Month JANUARY Day 15 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 JANUARY 1961
9. AGE (in years last birthday) 7 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KENNETH C. HILL		14. MOTHER'S MAIDEN NAME LUCILLE K. BRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Kenneth C. Hill, 7012 E. Baker St, Ft Geo G. Meade, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) DUE TO (c) 775X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 January 1961 to 15 Jan 1961 that (I) (we) last saw the deceased alive on 15 Jan 1961 and that death occurred at 11:20PM from the causes and on the date stated above.			
22a. SIGNATURE Sherman S. Robinson M.D.		22b. DATE 15 January 1961	
22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, CAPT, MC		22d. ADDRESS U.S. ARMY HOSPITAL, FT. GEO. G. MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 16 Jan 61	
23c. NAME OF CEMETERY OR CREMATORY USA Hospital		23d. LOCATION (City, town, or county) (State) Ft Geo G Meade, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Lenden - 2/41 MSC		25a. REC'D BY REGISTRAR JAN 18 '61	
ADDRESS USAH FGG Meade, Md		25b. REGISTRAR'S SIGNATURE Robert L. Kuntz	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00131

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) 8481 Garden Road		d. STREET ADDRESS 8481 Garden Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Marie Hindle		4. DATE OF DEATH Month Day Year January 14, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1906
9. AGE (In years lost birthday) 54 yrs		IF UNDER 1 YEAR Months Days Hours Min 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England ✓	
13. FATHER'S NAME James F. McCormick		14. MOTHER'S MAIDEN NAME Rose A. D'Acy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Mr. Thomas J. Hindle	
17. INFORMANT Mr. Thomas J. Hindle		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the throat 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 20 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 20 1960 to Jan 14 1961 , that (I) (we) last saw the deceased alive on Jan 13 1961 , and that death occurred at 12 P. M. from the causes and on the date stated above			
22a. SIGNATURE R. M. McLaughlin		22b. DATE SIGNED 1/14/61	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Monrovia Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 18, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	23d. LOCATION (City, town, or county) (State) West. Roxbury, Massachusetts
24. FUNERAL DIRECTOR'S SIGNATURE George J. Ronce		25. REGISTRAR'S SIGNATURE Arthur L. Hines	



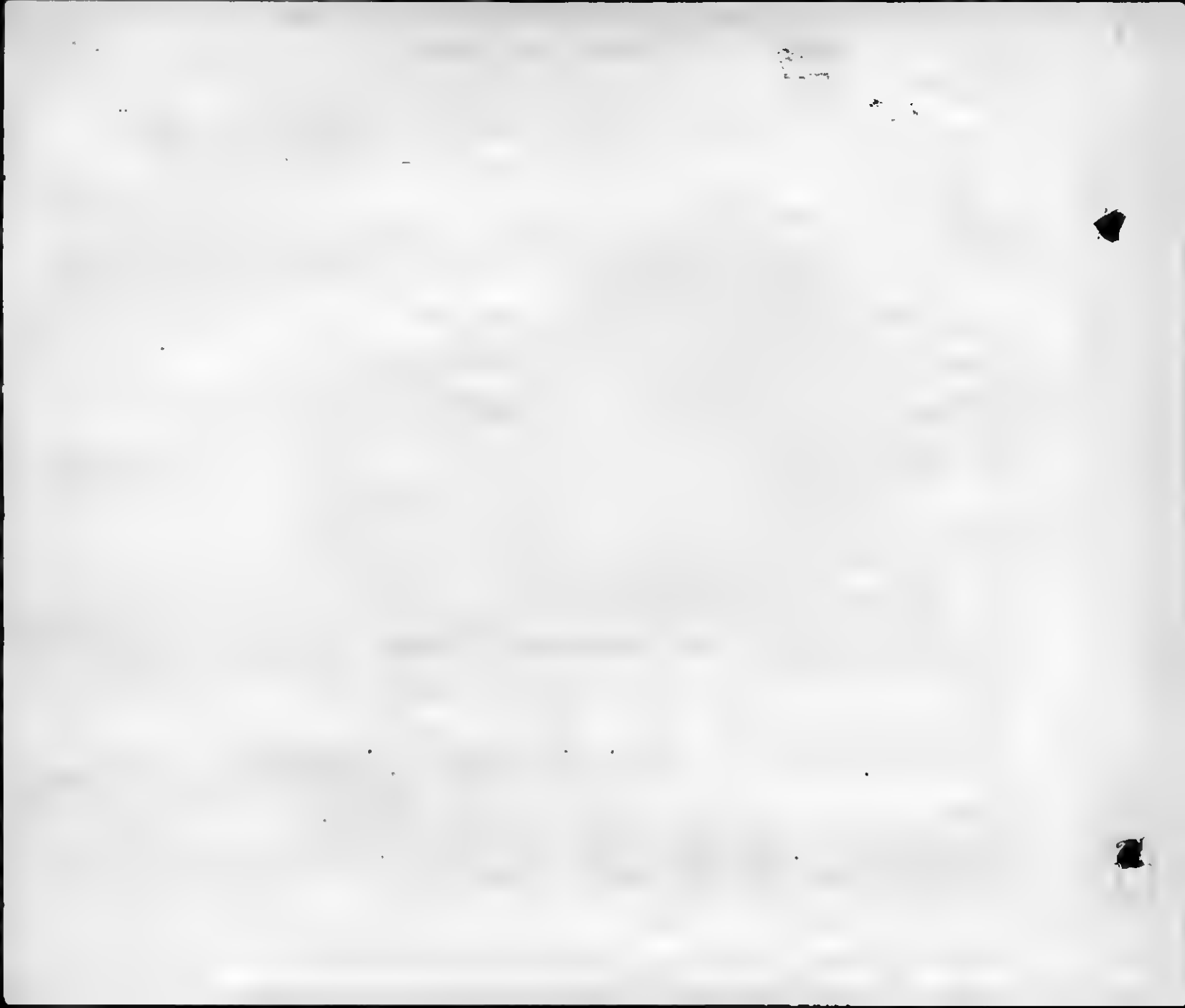
CERTIFICATE OF DEATH

00132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 8 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle R. Last HUNTT				4. DATE OF DEATH Month January Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23-1906	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54	IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Bd. Permits for C.A. Co Md				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Charles Harbough				14. MOTHER'S MAIDEN NAME W. H. HUNTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --- (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT A. MELVIN HUNTT #2				Address ---			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HYPERTENSION DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- (b) --- (c) ---							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 20, 1961 to Jan. 20, 1961 , that I last saw the deceased alive on Jan. 20, 1961 , and that death occurred at 10:20 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 71 Franklin St., Annapolis, Maryland				DATE SIGNED 1/21/61			
ACTUAL SIGNATURE Edward S. Beck				M.D. ---			
PHYSICIAN'S NAME (Type) Edward S. Beck				Ann timer, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-1961		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE JAN 25 '61	
24b. REGISTRAR'S SIGNATURE Arthur E. Huns							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



127

CERTIFICATE OF DEATH

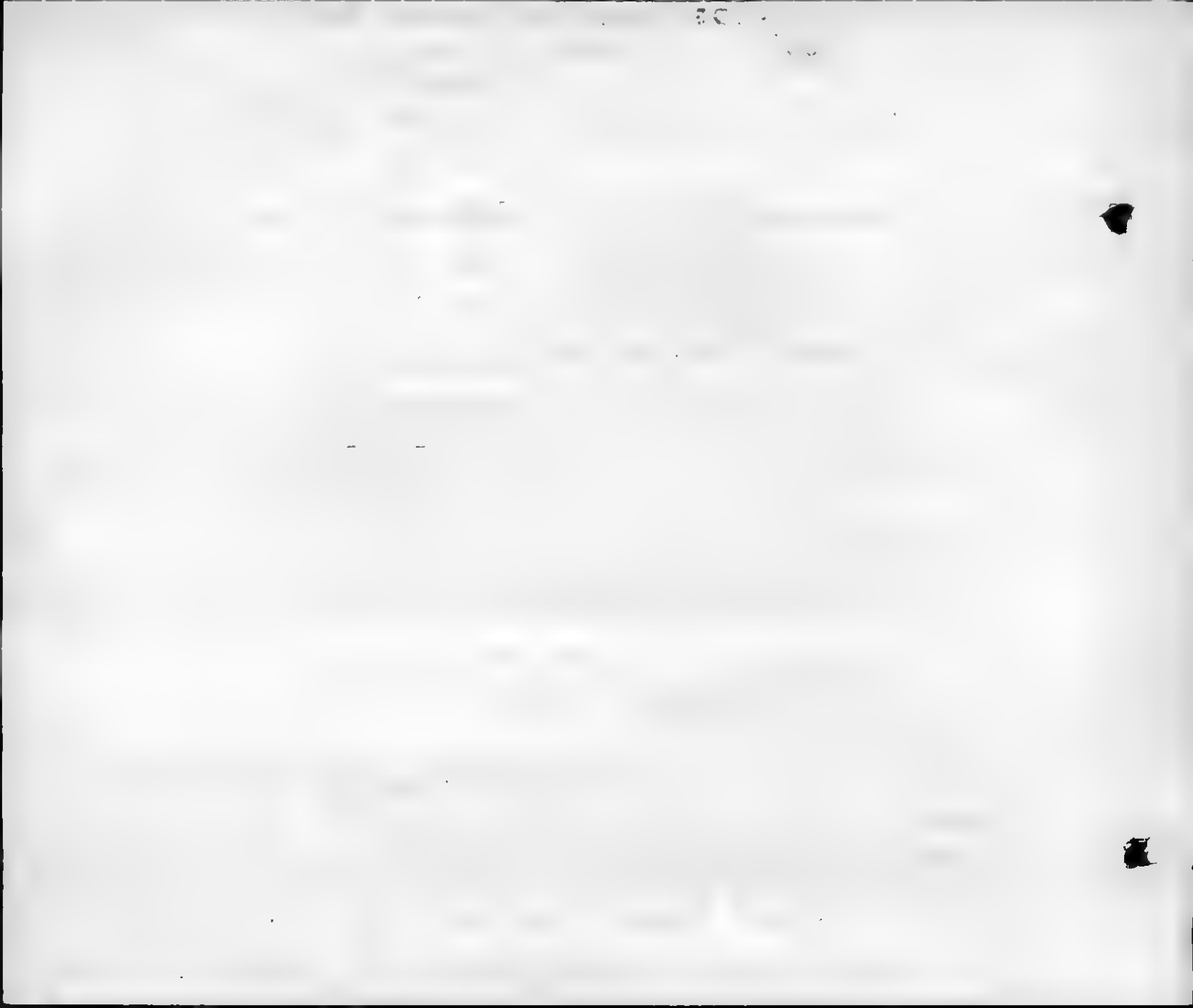
00133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 10 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1311 Maple Street		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis d. STREET ADDRESS 1311 Maple Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle M Last HYATT		4. DATE OF DEATH Month JANUARY Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1887
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Repair		10b. KIND OF BUSINESS OR INDUSTRY Prop.shoe repair	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs Ida Hyatt- Wife- same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) + Arteriosclerotic C.V.D. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes M.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19____, to 1-24- , 19 61 , that I last saw the deceased alive on 1-20 , 19 61 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank M. Shipley M.D. 176 Ch. ... St. 1-25-61 PHYSICIAN'S NAME (Type) Frank Shipley MD Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1961	
22c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JAN 26 '61	
24b. REGISTRAR'S SIGNATURE Caroline S. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



128

CERTIFICATE OF DEATH

Reg. Dist. No. 00134

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Pleasant Beach</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pasadena RFD</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena - Mt. Pleasant Beach</i>	
f. STREET ADDRESS <i>Rt. 6 - Box 251</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE</i> First <i>WILLIAM</i> Middle <i>INSLEY</i> Last		4. DATE OF DEATH <i>JAN</i> Month <i>13</i> Day <i>1961</i> Year	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 8, 1892</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Cutter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>grocery store</i>	
11. BIRTHPLACE (State or foreign country) <i>Cambridge, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William S. Insley</i>		14. MOTHER'S MAIDEN NAME <i>Maria Pritchett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212 38 4430</i>	
17. INFORMANT <i>MRS INSLEY</i>		Address <i>SAME</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN 7</i> , 19 <i>61</i> , to <i>JAN 13</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>JAN 13</i> , 19 <i>61</i> , and that death occurred at <i>7:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8471 FT. SMALLWOOD ROAD PASADENA, MARYLAND</i> DATE SIGNED <i>1/13/61</i>			
ACTUAL SIGNATURE <i>J. J. Brady Smith</i>		M.D. <i>1/13/61</i>	
PHYSICIAN'S NAME (Type) <i>J. J. BRADY SMITH</i>		<i>PASADENA, MARYLAND</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried 17 May '61</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Eden Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Bonny RFD, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. B. Bunn</i>		ADDRESS <i>6401 Bonny Rd, Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Charles E. Fenn</i>	
DATE <i>JAN 18 '61</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

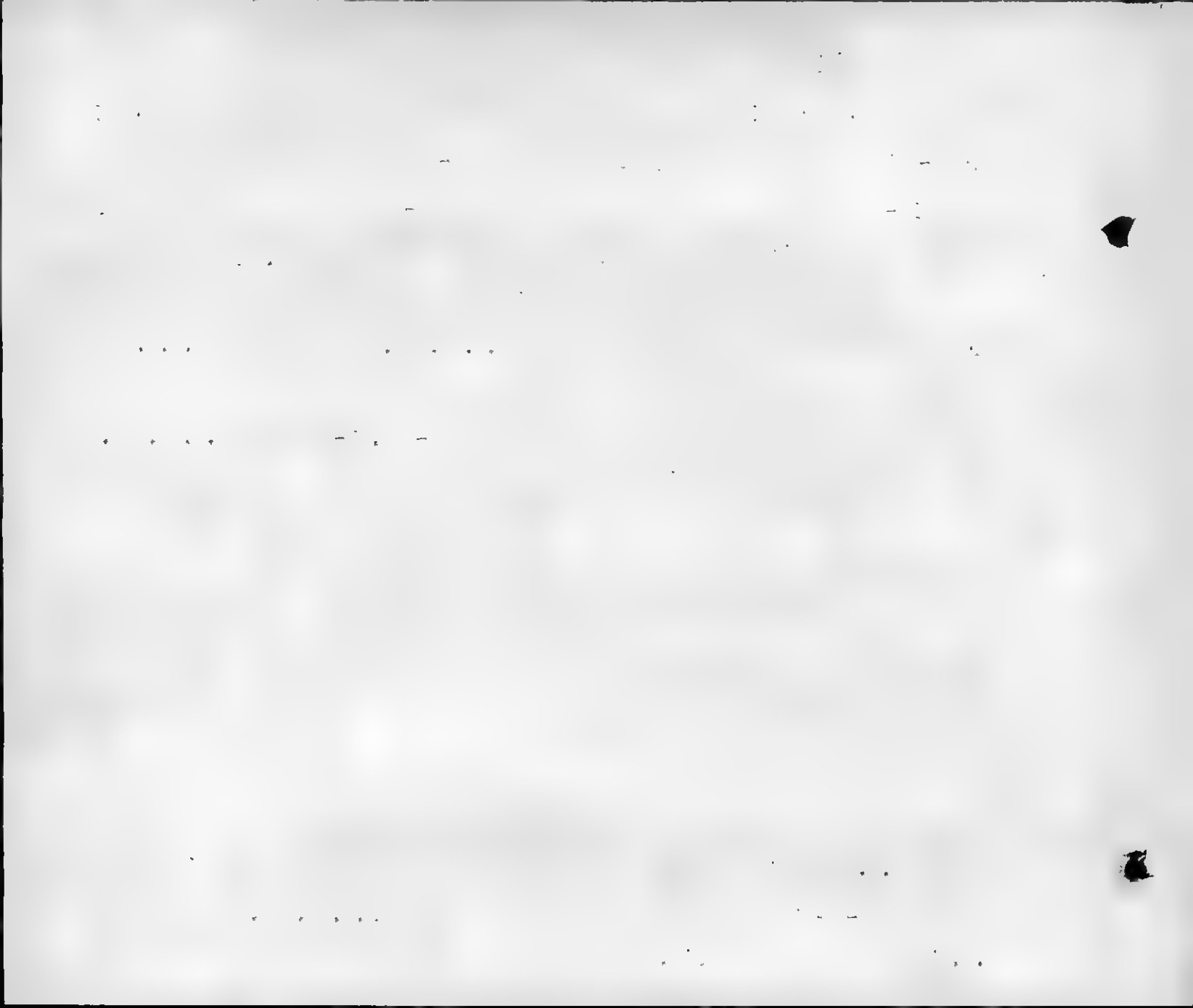
00135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mill Swamp		c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mill Swamp			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 - Box 472				d. STREET ADDRESS Route 1 - Box 472			
3. NAME OF DECEASED (Type or print) First Middle Last Phillip Jackson				4. DATE OF DEATH Month Day Year Jan. 21 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1887 ?			
9. AGE (In years last birthday) 73 ?		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) A.A.Co. Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mamie Turner - Rt. 1-Box 472 A.A.Co. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. due to (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE E.G. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/21/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-61		22c. NAME OF CEMETERY OR CREMATORY Chews Chapel			
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JAN 30 '61			
24b. REGISTRAR'S SIGNATURE C. H. G. Kraus		24c. LOCATION (City, town, or county) (State) A.A.Co. Md.					

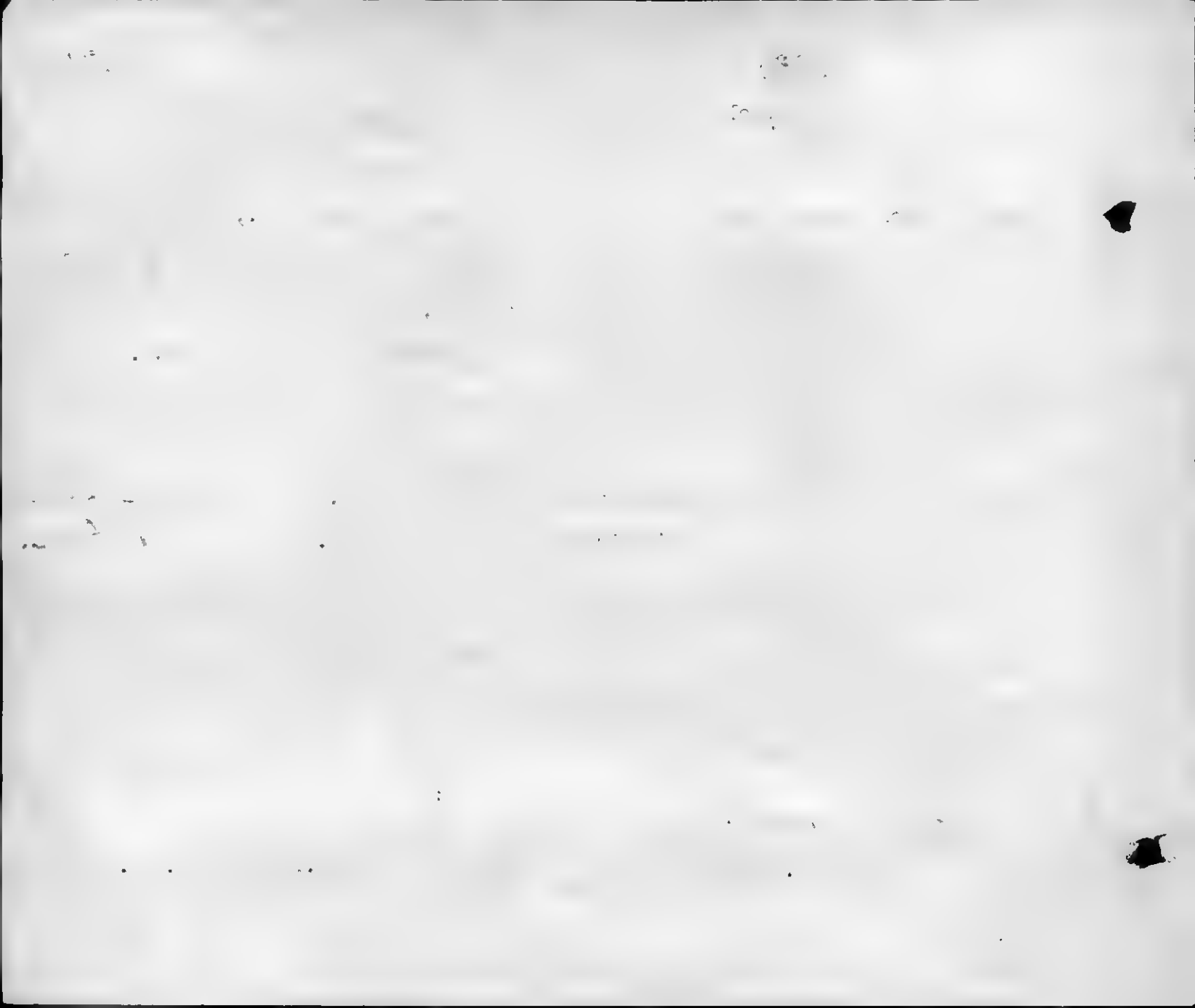
MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Arthur L. Kraus

VR A (4)
15M 9/60



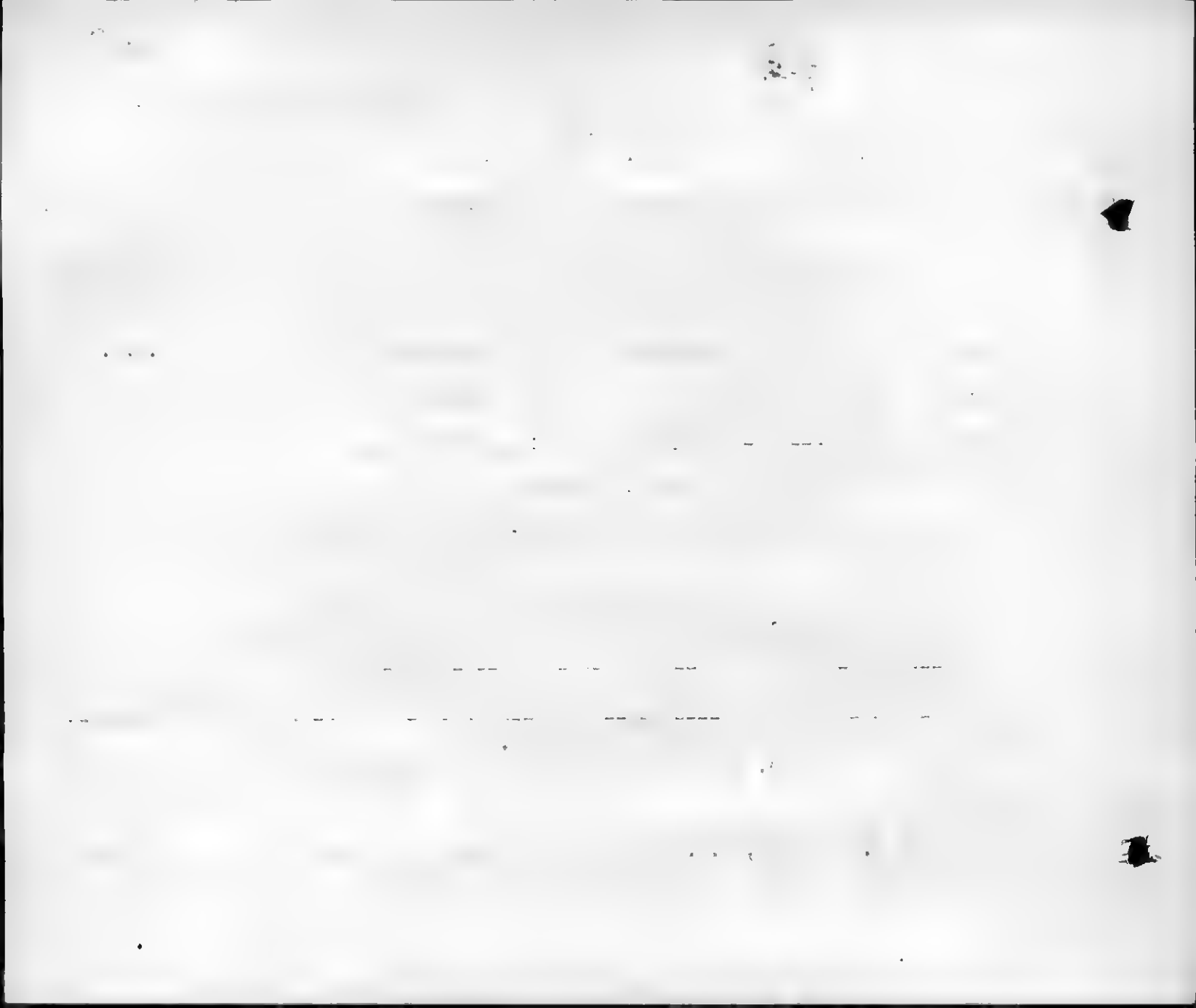
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

131
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00137

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Pinkney Middle Johnson Last Johnson		4. DATE OF DEATH Month 1 Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 1 Days 27 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Hypertensive Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month 19 Day 13 Year 61 Hour 1:00 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from Oct. 13, 1961 to Jan. 27, 1961 , that (I) (we) last saw the deceased alive on Jan. 27, 1961 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 1/27/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-61		23b. DATE THEREOF 1-31-61	
23c. NAME OF CEMETERY OR CREMATORY St. Agnes		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.		25a. REC'D BY REGISTRAR Feb 2 '61	
25b. REGISTRAR'S SIGNATURE William E. Reese		25c. DATE Feb 2 '61	



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(1)

132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00138

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				e. STREET ADDRESS Box 262 Seely on Bay			
3. NAME OF DECEASED (Type or print) First Edmund Middle V. Last Jones				4. DATE OF DEATH Month Jan. Day 6 Year 1961			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME SAMUEL E. JONES				14. MOTHER'S MAIDEN NAME HARRIETT FINK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT AGNES B. JONES # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease DUE TO Chronic obstructive pulmonary disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE Chronic obstructive pulmonary disease (c) Chronic obstructive pulmonary disease						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to Jan 6, 1961 , that (I) (we) last saw the deceased alive on Jan 6, 1961 , and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Elmer G. Linhardt				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/6/61	
22c. PHYSICIAN'S NAME (Type) Dr. Elmer G. Linhardt				22d. ADDRESS 3 Chesapeake Ave. Annapolis, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-10-1961		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.		23d. LOCATION (City, town, or county) (State) WASH. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR, SONS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE Charles L. Harris	

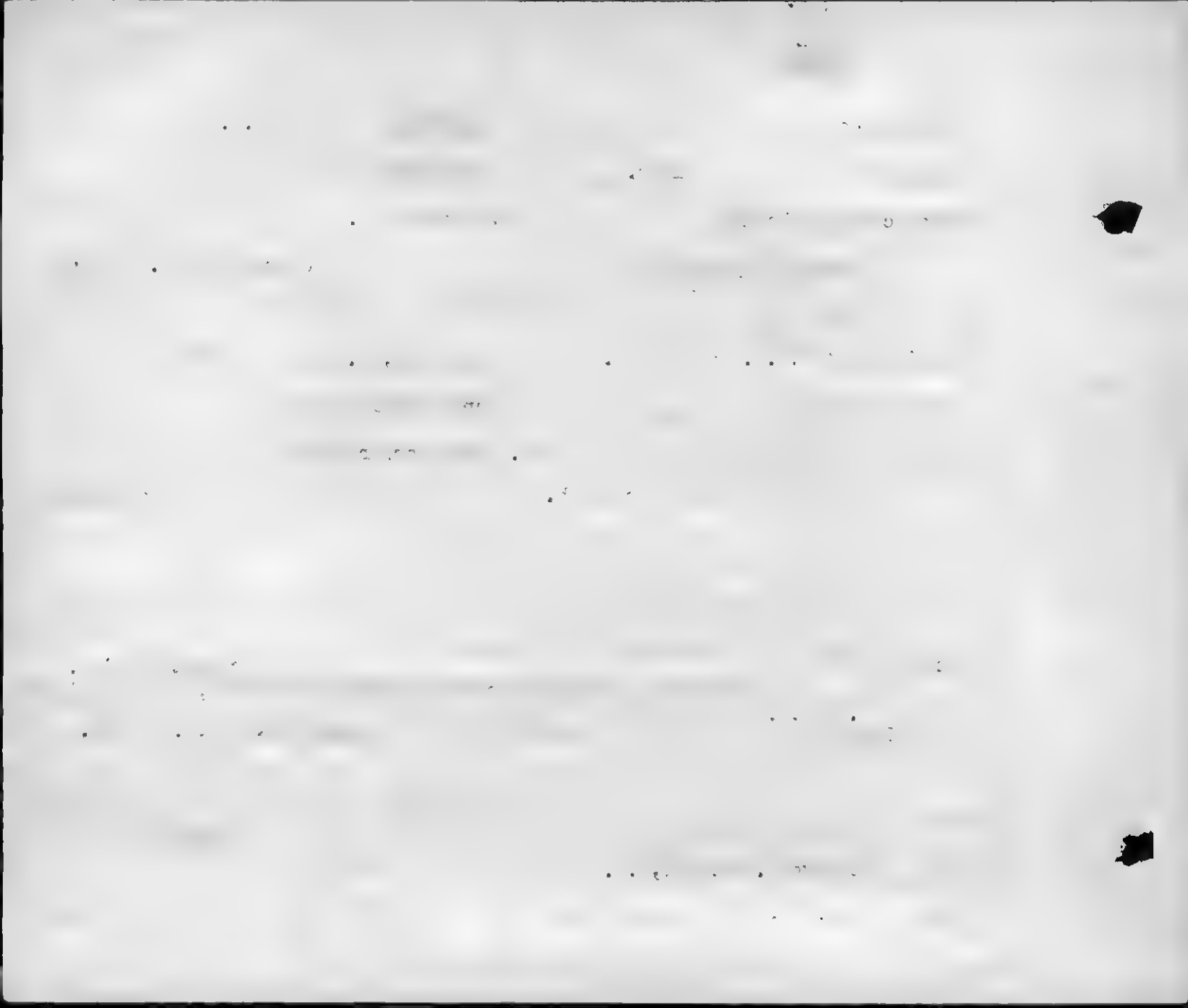


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an agent is necessary, it should be executed by the agent. The agent should be the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00139

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Curtis Bay		c. LENGTH OF STAY IN b 1 hr.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY A.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25		d. STREET ADDRESS 129 Meadow Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Thomas Henry Koerner		4. DATE OF DEATH January 26th. 19 61		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/07		9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship fitter at U.S.A. Coast Guard.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Koerner		14. MOTHER'S MAIDEN NAME Lena Weitzel Weitzel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Lola Koerner (wife)															
17. INFORMANT Mrs. Lola Koerner (wife)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charred to death. 916.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Few seconds		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. (caught on fire.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was working on the Chesapeake Coast Guard Cutter, when his clothes		20c. TIME OF INJURY Month, Day, Year 9.20 A.M. 1/26/61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arundel Cove		20f. (City or town) Curtis Bay, A.A. Md.													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/26/61		ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1961		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or country) Baltimore, Maryland		23. FUNERAL DIRECTOR <i>George J. Jones</i>		ADDRESS 4001 Ritchie Hwy. (25)		24a. REC'D BY REGISTRAR FEB 2 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



134

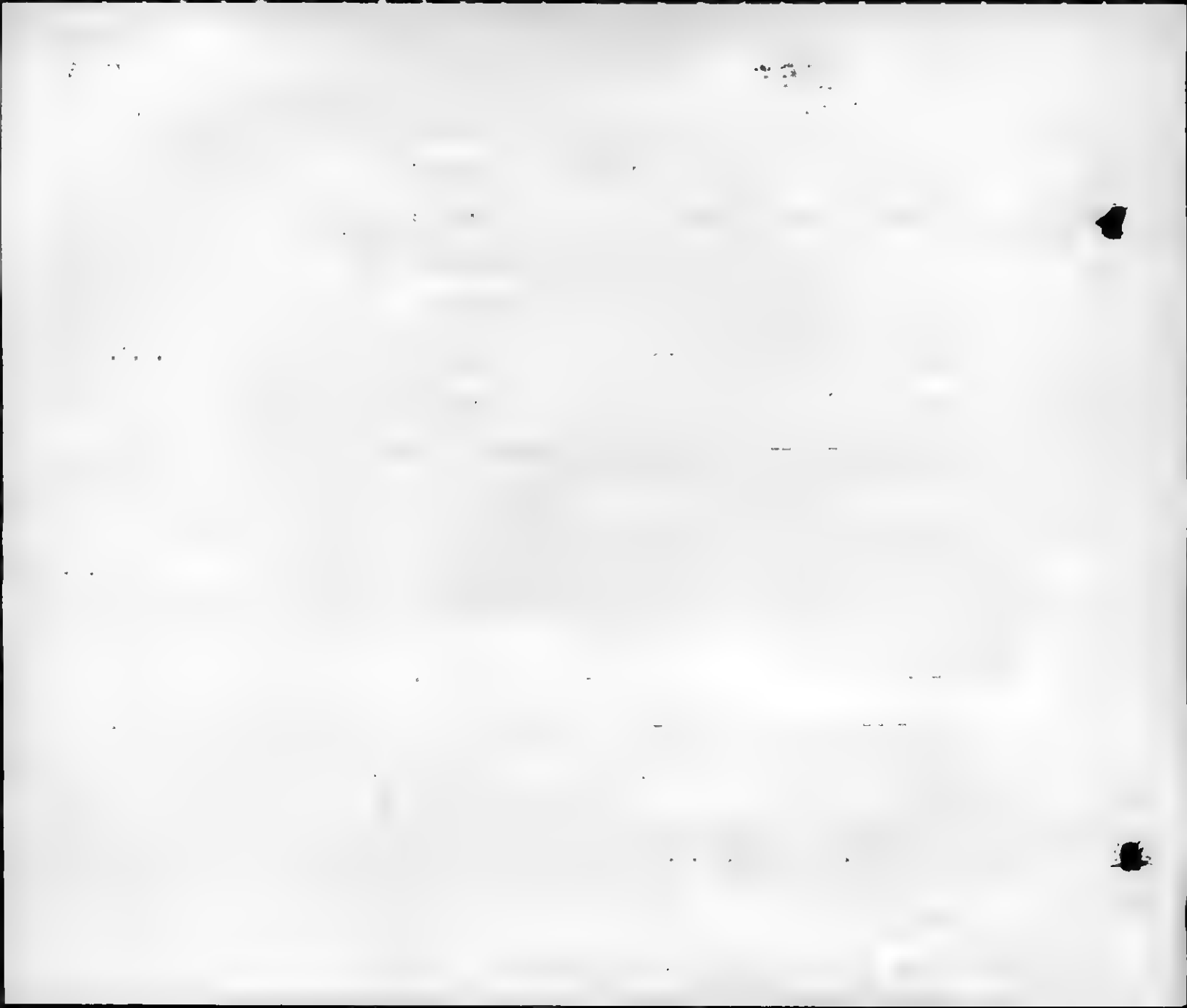
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Annapolis, Maryland</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X USNH Hospital / OFFICE AFB / Baltimore</u>			
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Lidard</u> Last <u>LANCASTER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17th</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-19</u>	9. AGE (In years last birthday) <u>42</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John LIDARD</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite McCULLOUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>---</u>		17. INFORMANT <u>Husband - 518 6th Street, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>S81.1</u> IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Alcoholism</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>60</u> , to <u>1-17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1-17</u> , 19 <u>61</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USNH, Annapolis, Maryland</u> <u>1-18-61</u>							
ACTUAL SIGNATURE <u>Sylvan Busch</u>				M.D. <u>USNH, Annapolis, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Sylvan (n) BUSCH, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. S. Mac Neth</u>				ADDRESS <u>Frederick & Wade Ave-28</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Page 4

VR AIS (4)
TSM 9/59

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

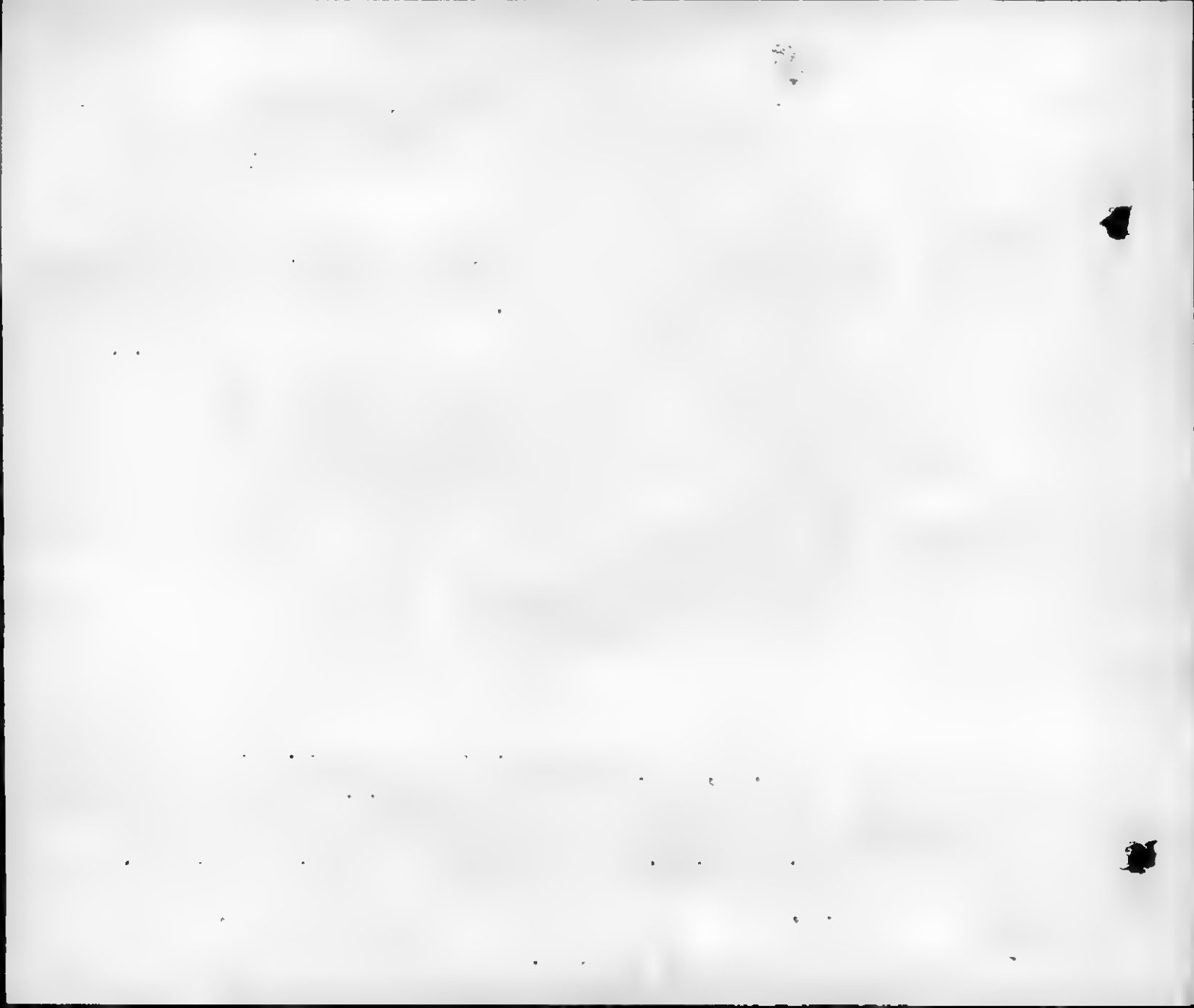
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00087

136

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Doris Middle Anne Last LITTLE				4. DATE OF DEATH Month January Day 11 Year 1961			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1961	
9. AGE (In years last birthday) 2 yrs.		10. UNDER 1 YEAR Months 2 Days 2 Hours 13		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Carlton LITTLE				14. MOTHER'S MAIDEN NAME Doris Ilene BEARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome - Probable hyaline membrane disease 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 48 hr 48 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21 I certify that (I) (the undersigned) attended the deceased from Jan. 9, 1961 to Jan. 11, 1961 that (I) (we) last saw the deceased alive on Jan. 10, 1961 , and that death occurred at _____ M. from the causes and on the date stated above.							
22a. SIGNATURE James I. Hudson, Jr.				6:15 A.M. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.				22d. ADDRESS River Club Estates, Edgewater, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			



CERTIFICATE OF DEATH

Reg. Dist. No.

C0089

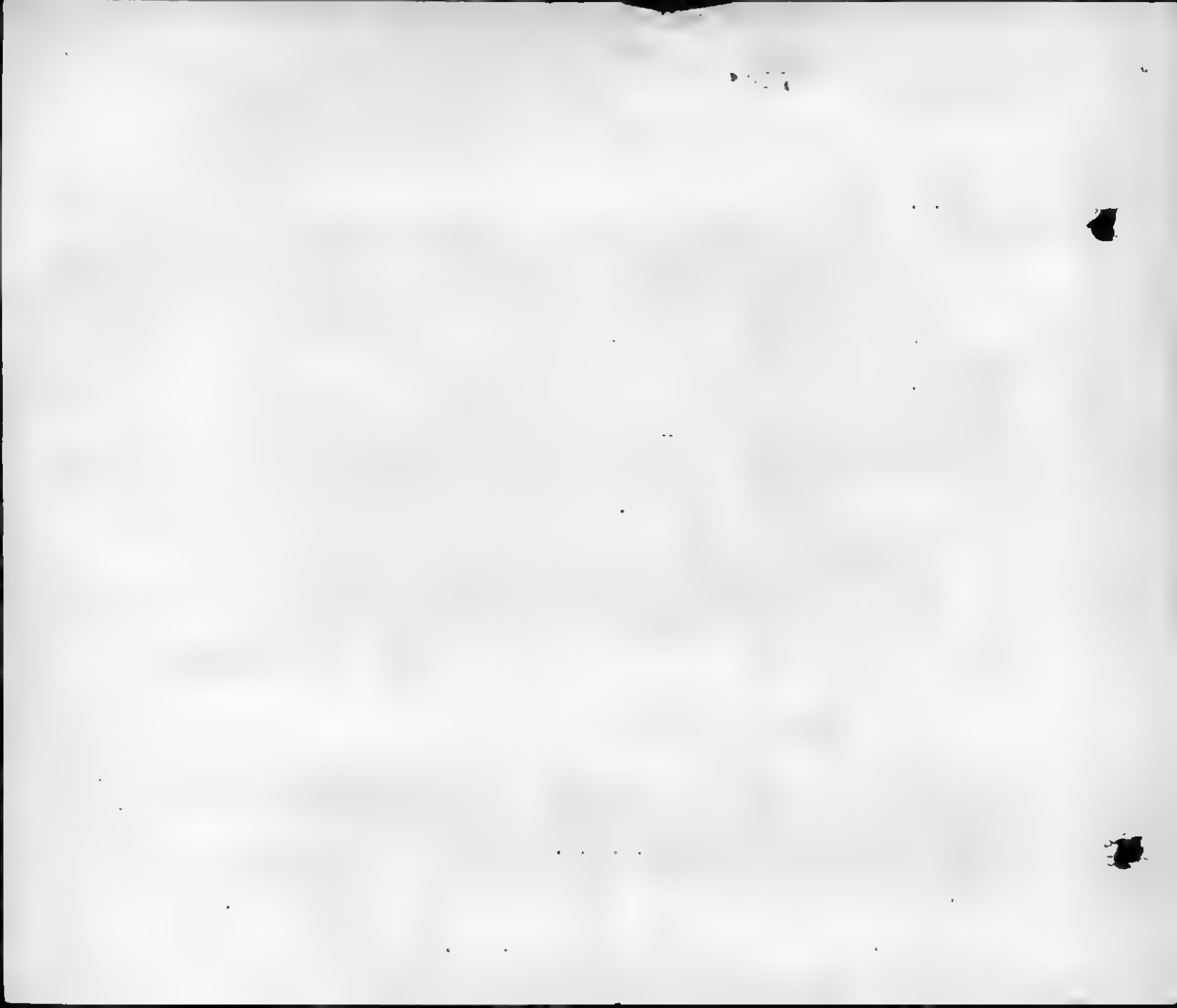
137

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Holabird	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital		d. STREET ADDRESS 2107 2-B Cummins Apts	
3. NAME OF DECEASED (Type or print) First MARCHUS Middle D Last LOGAN		4. DATE OF DEATH Month JANUARY Day 22 Year 19 61	
5. SEX Male	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 60
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Logan		14. MOTHER'S MAIDEN NAME Carol Bonaparte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father, (See 2d)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, bacterial, organism unknown at/ DUE TO present/ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I examined the deceased from 22 Jan 19 61, to 22 Jan 19 61, and that death occurred at 12:30 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 22 Jan 61 DATE SIGNED			
ACTUAL SIGNATURE [Signature]		M.D. US Army Hospital Ft Geo G Meade, Md	
PHYSICIAN'S NAME (Type) LAMAR CAMPBELL, Capt., M.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-61	22c. NAME OF CEMETERY OR CREMATORY Log Providence	22d. LOCATION (City, town, or county) (State) Columbia, Mo.
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law 802 Madison Avenue, Balto., Md		24a. REC'D BY REGISTRAR DATE JAN 24 '61	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVVV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

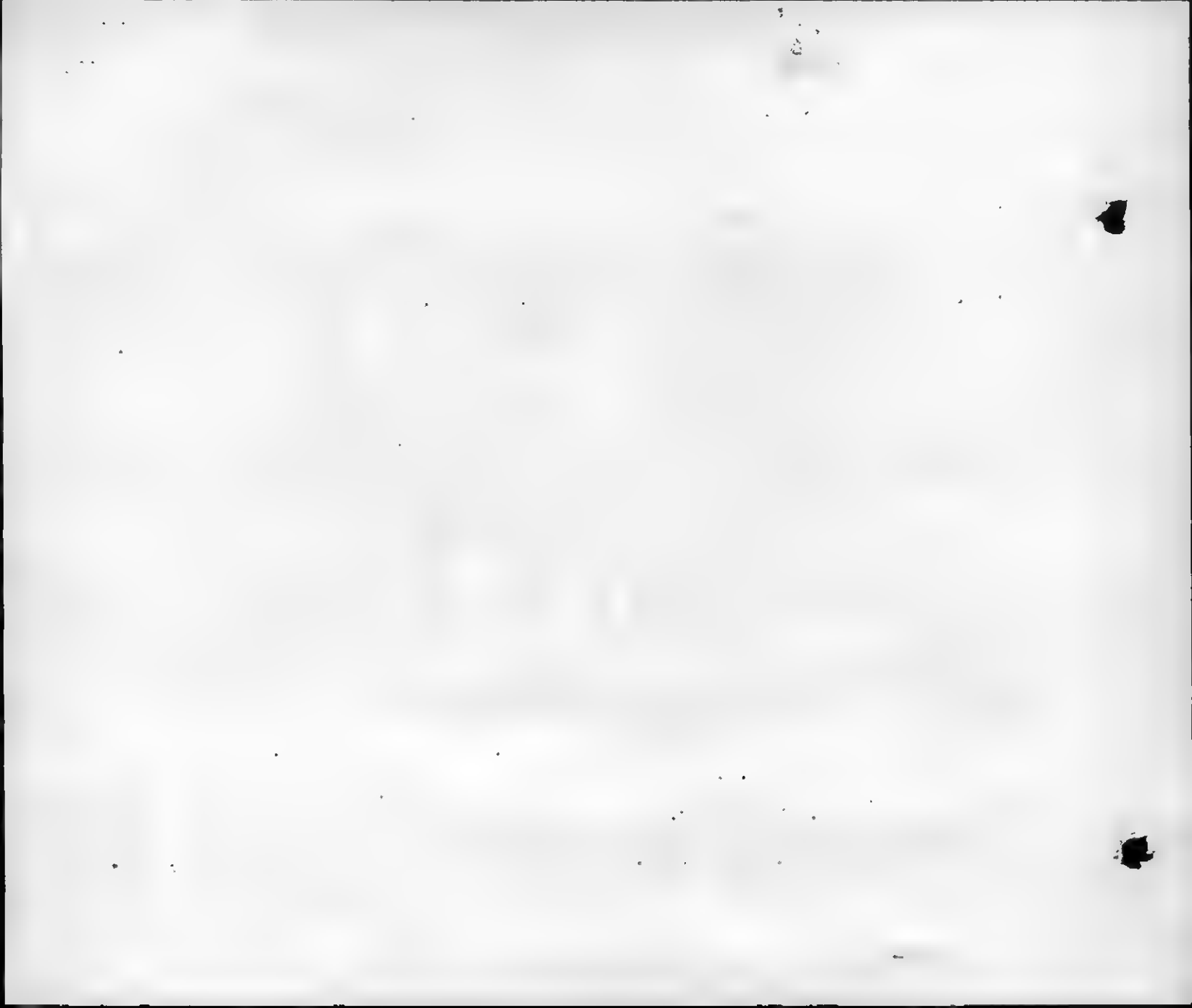
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00090

138

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b RURAL - Lothian			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MORELAND		4. DATE OF DEATH Month Day Year January 7 1961		5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1961		9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 7 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Clifton MORELAND				14. MOTHER'S MAIDEN NAME Esther Doreather JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - Immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan. 7, 1961 to Jan. 7, 1961 , that (I) (we) last saw the deceased alive on Jan. 7, 1961 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James I. Hudson, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/10/61			
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.		22d. ADDRESS River Club Estates, Edgewater, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-11-1961		23c. NAME OF CEMETERY OR CREMATORY Lothian		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Williams		25a. REC'D BY REGISTRAR Jan 11 '61		25b. REGISTRAR'S SIGNATURE Charles E. Harris			

MEDICAL CERTIFICATE ON



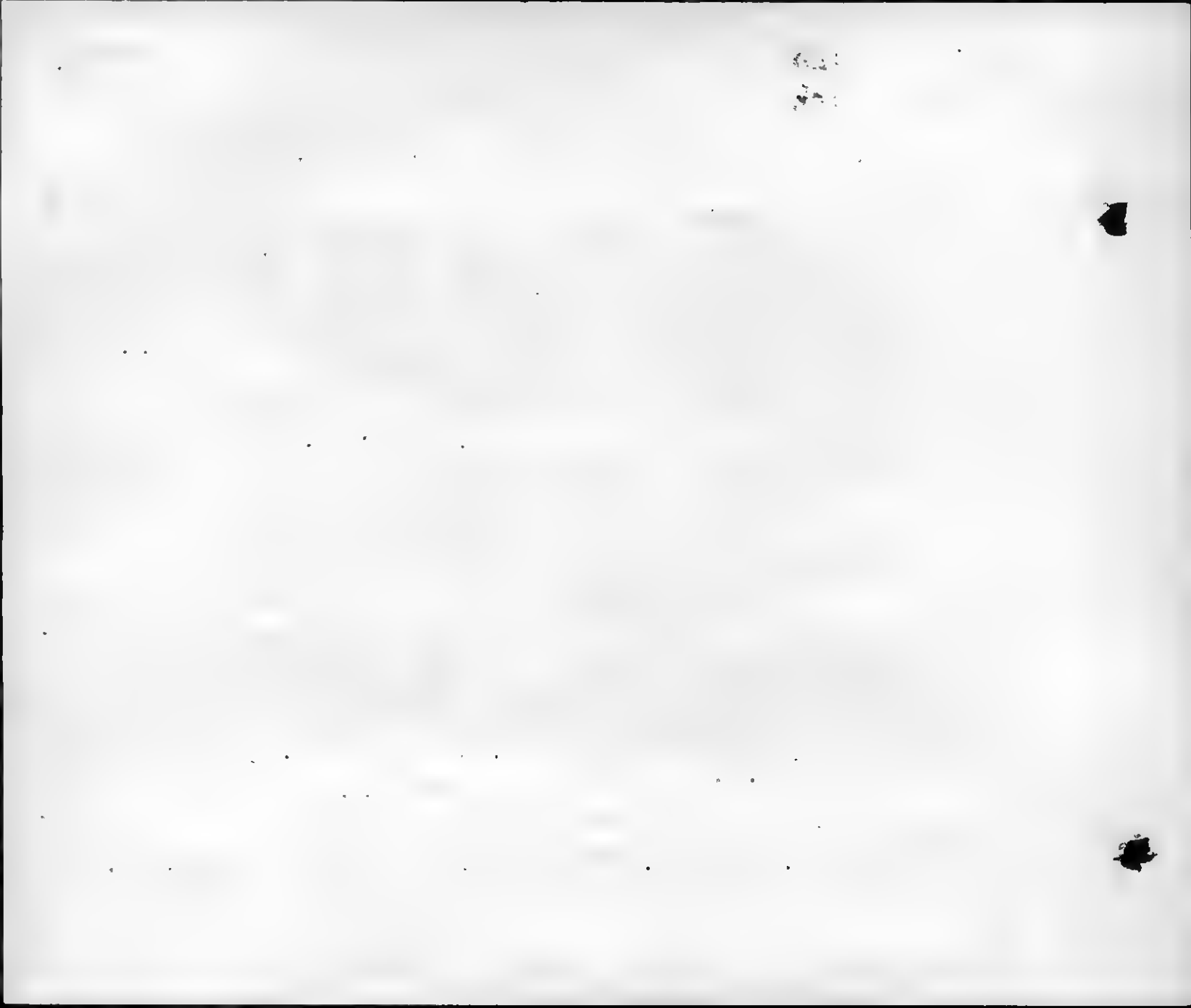
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

139

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0091

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORELAND</u>		4. DATE OF DEATH Month Day Year <u>January 8 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 7, 1961</u>
9. AGE (In years last birthday) <u>23</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <u>05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Clifton MORELAND</u>		14. MOTHER'S MAIDEN NAME <u>Esther Doreather JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity - immaturity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Jan. 7, 1961</u> , to <u>Jan. 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 8, 1961</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>James I. Hudson, Jr. M.D.</u>		22b. DATE SIGNED <u>1/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James I. Hudson, Jr.</u>		22d. ADDRESS <u>River Club Estates, Edgewater, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-11-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Zion</u>		23d. LOCATION (City, town, or county) (State) <u>Lothian Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett Arundel</u>		25a. REC'D BY REGISTRAR <u>11 '61</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

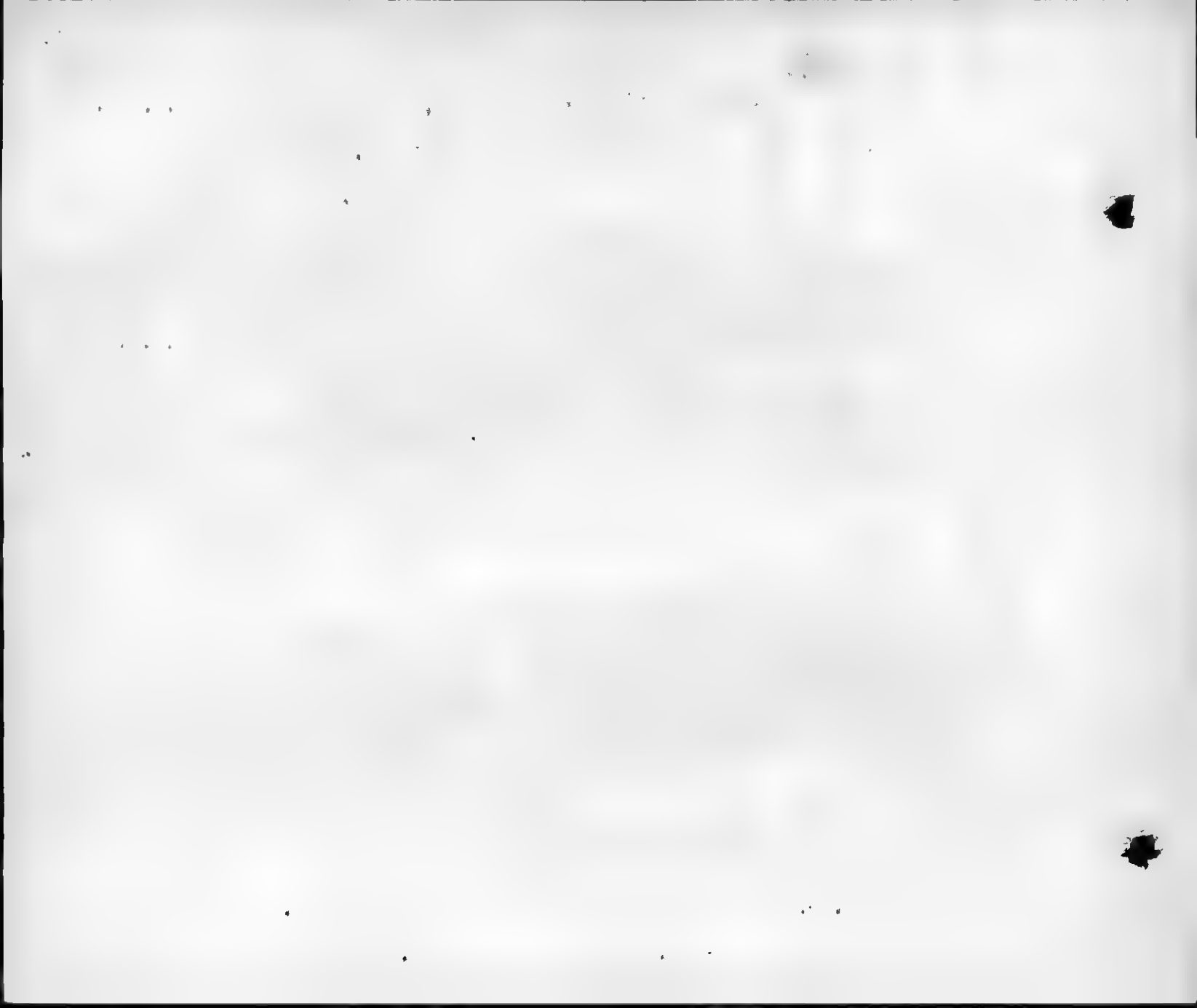
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00142**

1. PLACE OF DEATH a. COUNTY 387 Marley Ave, Glen Burnie Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Md.	
3. NAME OF DECEASED (Type or print) MARY^{First} F^{Middle} NECESSON^{Last}		4. DATE OF DEATH 1/29/61 Month Day Year	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17 1894
9. AGE (In years lost birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Joseph G. Necesson Address 387 Marley Ave, Glen Burnie Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency 008X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12 , 19 61 , to 1/29 , 19 61 , that I last saw the deceased alive on 1/24 , 19 61 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Leopold, Jr. M.D.		ADDRESS (Street, city or town, state) 425 S. Ritchie Hwy, Glen Burnie, Md.	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type)		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	1.30.61	Loudon Park	Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 E. Fort Ave Balto Md.	
24a. REC'D BY REGISTRAR DATE JAN 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Fraws	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and the funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

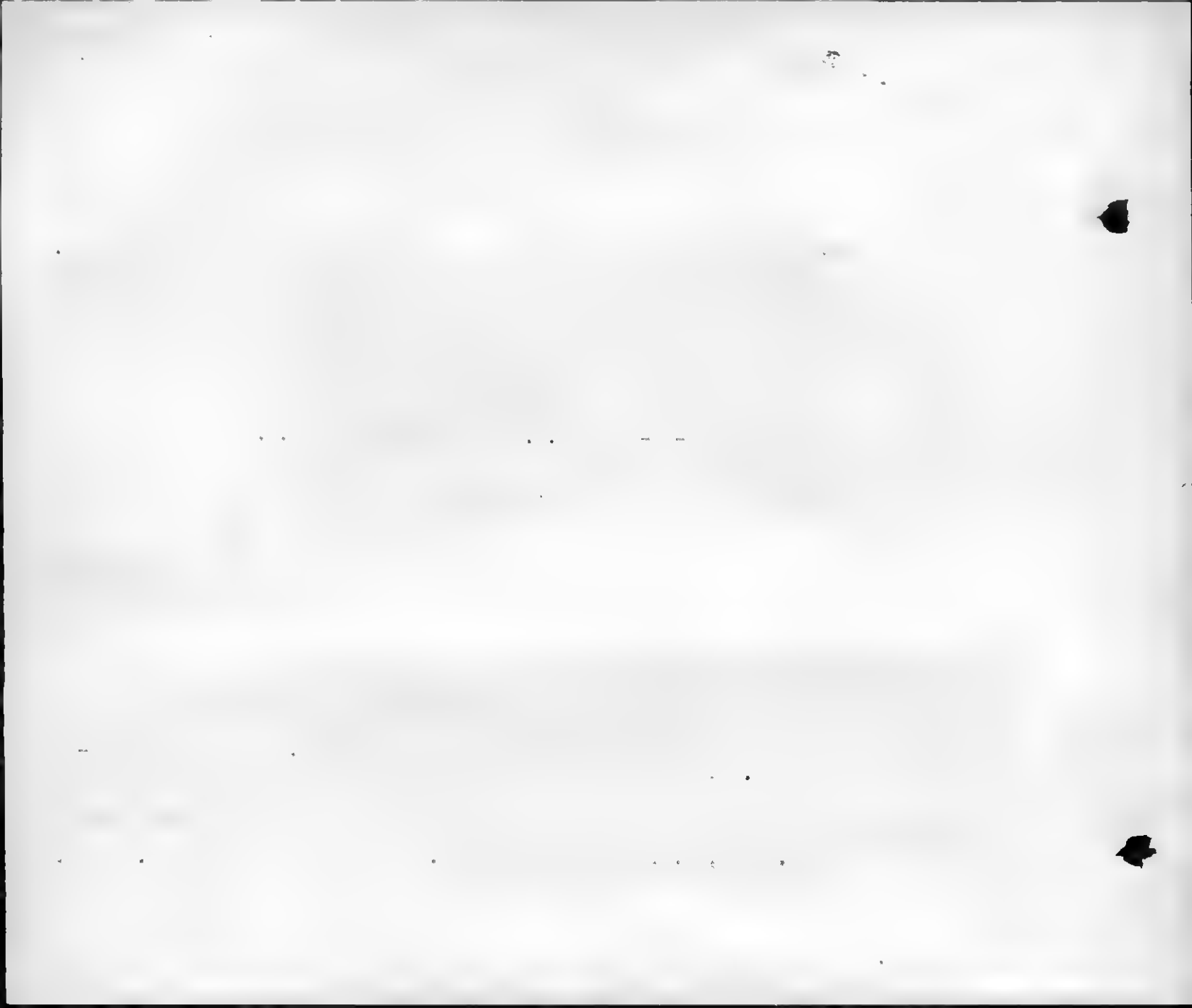
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00143

141

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown ? b. COUNTY ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 120 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) Martha Parran				4. DATE OF DEATH Month January 12, Day 19 Year 61			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1887	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 3 Days 14	IF UNDER 24 HRS Hours 14 Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown ?		12. CITIZEN OF WHAT COUNTRY? Unknown ?	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-7412		17. INFORMANT P.T. Merani-Baltimore D.P.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 023 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tertiary lues DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from September 5, 1960 , to Jan. 12, 1961 , that (I) (we) last saw the deceased alive on Jan. 7, 1961 , and that death occurred at 10A.M. , from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE January 12, 1961			
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.				22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-14-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Charles R. Law	



TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

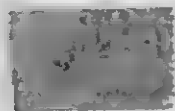
FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
00144									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u> c. LENGTH OF STAY IN It <u>Same</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>417 Magnolia St.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>417 Magnolia St.</u>				
3. NAME OF DECEASED (Type or print) <u>Reginald R. Perry</u>					4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1961</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>9/7/01</u>				
9. AGE (In years last birthday) <u>58</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min <u>42</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed (as retail credit)</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>				
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Balfour E. Perry</u>					14. MOTHER'S MAIDEN NAME <u>Mary H. Perry</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW II</u>					16. SOCIAL SECURITY NO. <u>67-1-1112</u>				
17. INFORMANT <u>Dr. J. H. Perry (son)</u>					Address <u>1112 Perry St.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>7-2-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>7-2-1</u> (b) <u>7-2-1</u> (c) <u>7-2-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>...</u>				
20c. TIME OF INJURY Month <u>1</u> Day <u>17</u> Year <u>1961</u> Hour <u>11</u> a.m. <u>19</u> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>...</u>					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave H. R. ...</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>...</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>1/17/61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>17th Jan. '61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>					22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>				
23. FUNERAL DIRECTOR <u>Glen Burnie, Md.</u>					24a. REC'D BY REGISTRAR <u>JAN 18 '61</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

60145

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Galesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Daniel Middle Peters Last		4 DATE OF DEATH Month 1 Day 26 Year 1961	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/12 6/1/12
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MARY (Address Peters 540 S. ... 17d		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour 0 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 12 19 57 to Jan. 26 19 61 that (I) (we) as saw the deceased alive on Jan. 26 19 61 and that death occurred at 5:00 from the causes and on the date stated above			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 1/26/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BLR A., CREMATION REMOVAL (Specify) 1/29/61		23c. NAME OF CEMETERY OR CREMATORY	
23b. DATE THEREOF 1/29/61		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25. REC'D BY REGISTRAR	
ADDRESS		DATE JAN 30 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

[Faint, illegible handwritten notes]

100-443886-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 32,9 1-27-61 et

CERTIFICATE OF DEATH

00146

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	c. LENGTH OF STAY IN 1b all his life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 101 Maple Lane	
3. NAME OF DECEASED (Type or print) First Middle Last Beatrice Katharine Lane Phleggs		4. DATE OF DEATH Month Day Year Jan. 19 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 2 1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Madison B Backman		14. MOTHER'S MAIDEN NAME Amelia J. Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Henry Phleggs		Address 101 Maple Lane, Glen Burnie, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Disease. 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 18 , 19 61 , to Jan 19 , 19 61 , that I last saw the deceased alive on Jan 18 , 19 61 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 101 Central Ave Jan 19, 1961			
ACTUAL SIGNATURE Jane S. Bellinger		M.D. 101 Central Ave	
PHYSICIAN'S NAME (Type) Jane S. Bellinger		Glen Burnie Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1/21/61	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	22d. LOCATION (City, town, or county) (State) Park, Elkridge, Howard Co.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kipkley		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	



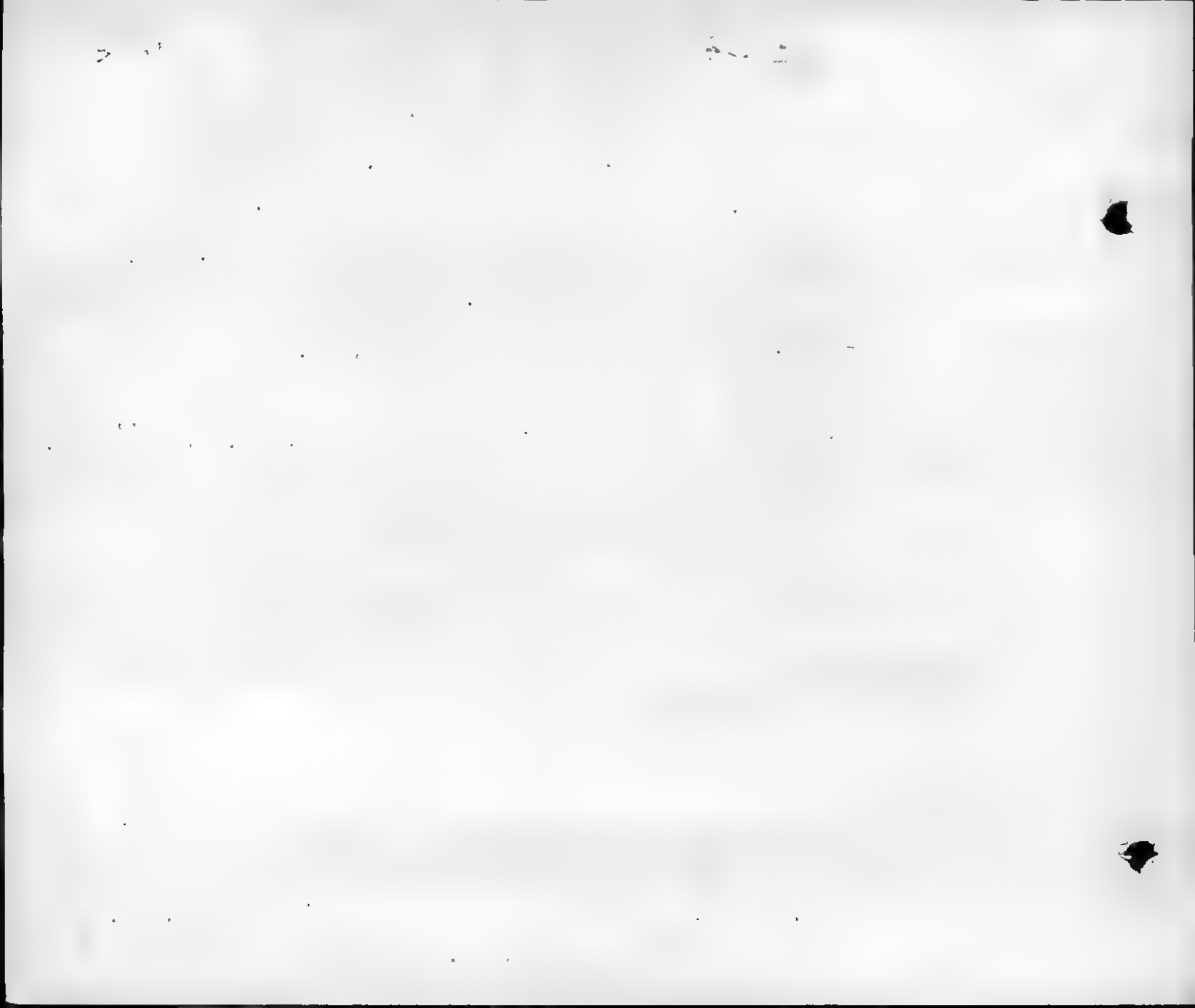
may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

145

C0147

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3rd and Outing Ave.</u>				e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Green Haven. Pasadena</u>			
f. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Joseph</u> Last <u>Plum</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15, 1893</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Anarew Plum</u>			
14. MOTHER'S MAIDEN NAME <u>Tina Pencek</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>215-09-2271</u>				17. INFORMANT Address <u>Balto., 31</u> <u>Miss Thelma Plum, 402 S. Register St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1959, to <u>15 Jan</u> , 1961, that (I) (we) last saw the deceased alive on <u>15 Jan</u> , 1961, and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Gene D. Trettin</u>				22b. DATE <u>16 Jan 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Gene D. Trettin, M.D.</u>	
22d. ADDRESS <u>715 Crain Rd Glen Burnie, Ind</u>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. DATE <u>16 Jan 1961</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

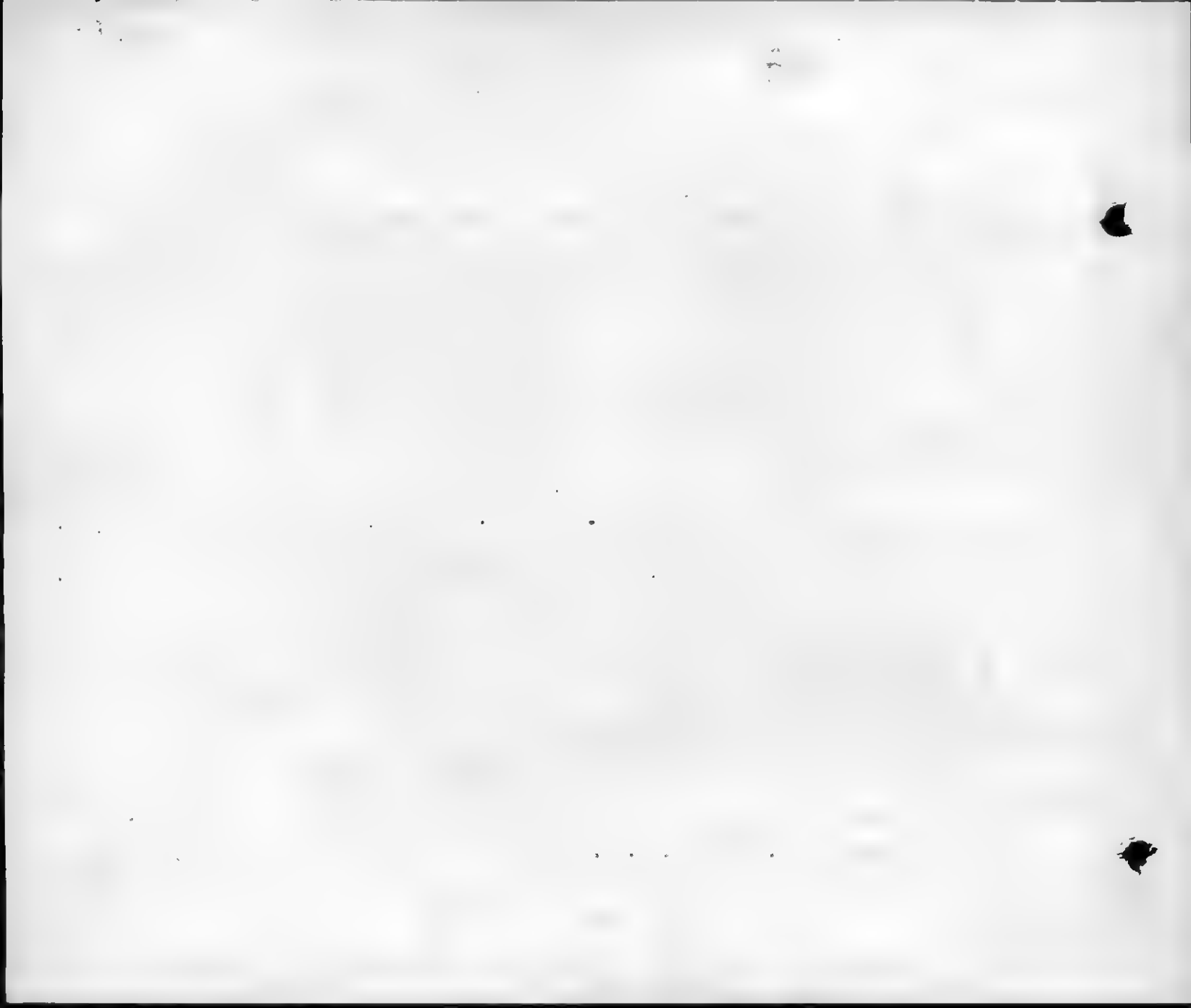


may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

146
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00148

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNE ARUNDEL</u>				c. LENGTH OF STAY IN 1b <u>ANNE ARUNDEL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Smithville St</u>				d. STREET ADDRESS <u>912 Smithville St</u>			
3. NAME OF DECEASED (Type or print) <u>Wilson Queen</u>				4. DATE OF DEATH <u>15 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1888</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Queen</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lillian Queen</u> Address <u>55 W. Wash. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thrombosis</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 14, 1961</u> to <u>January 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 15, 1961</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Theodore H. Johnson M.D.</u>				22b. DATE <u>Jan. 17, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>	
22d. ADDRESS <u>37 Calvert Street, Annapolis, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-20-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		23d. LOCATION (City, town, or county) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis</u>				25a. REC'D BY REGISTRAR <u>Jan 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



the funeral director, should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

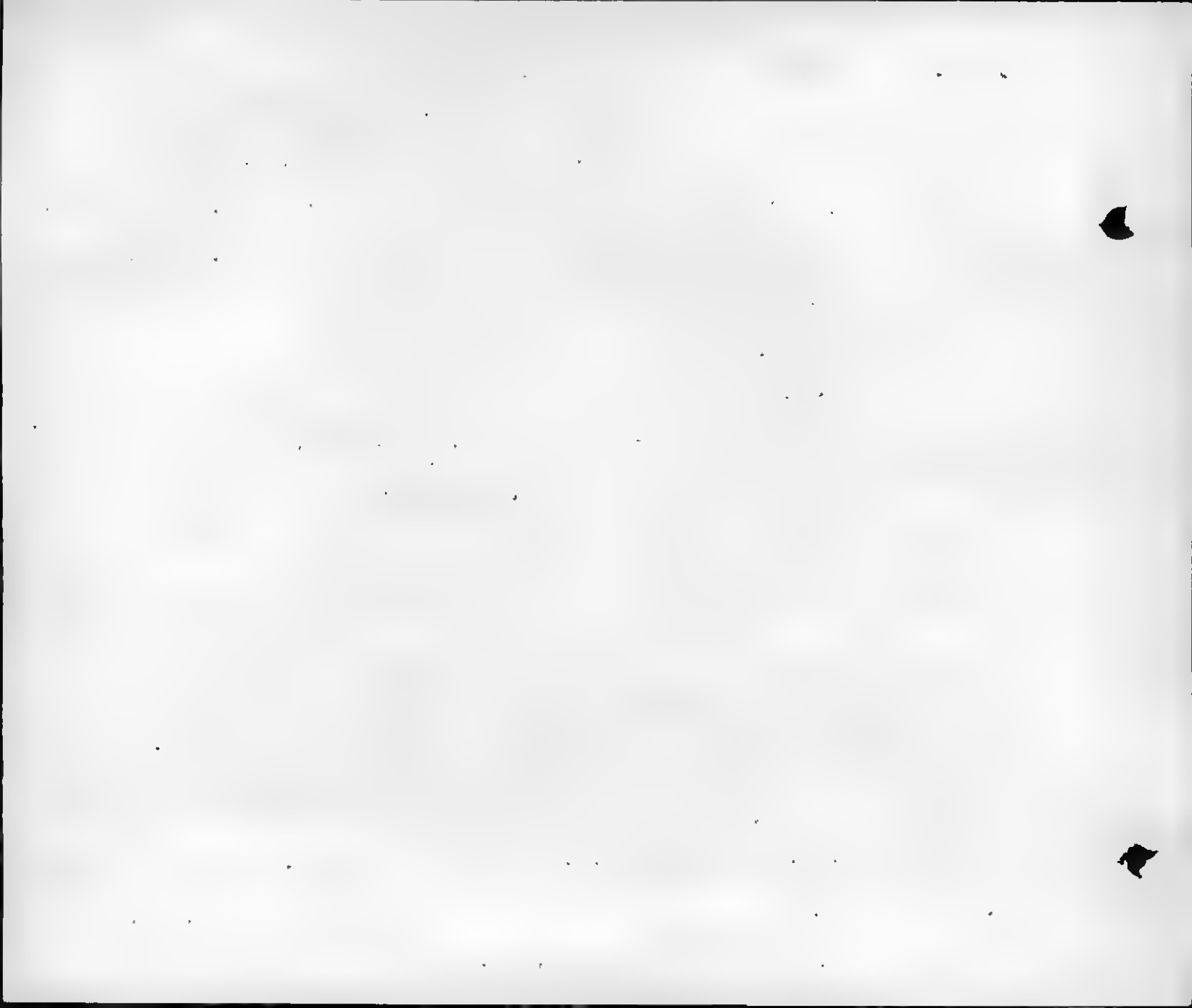
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60149

147

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 15 yrs.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (Marley Park)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Marley Neck Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 201 Marley Neck Rd.	
3. NAME OF DECEASED (Type or print) First Alonza Middle Little Last Reinhardt		4. DATE OF DEATH Month Jan. Day 3, Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger -Ret.		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Reinhardt		14. MOTHER'S MAIDEN NAME Emma Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 212-07-7867		17. INFORMANT Glen Burnie, Md. John D. Reinhardt, 205 3rd Ave SE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 19 53 to JAN 1 19 61 , that (I) (we) last saw the deceased alive on JAN 1 19 61 , and that death occurred at 11 A. M. from the causes and on the date stated above.					
22a. SIGNATURE C. R. MacDonald M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D.		22d. ADDRESS 204 Crain Hwy, SW, Glen Burnie,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town, or county) Baltimore 25, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION



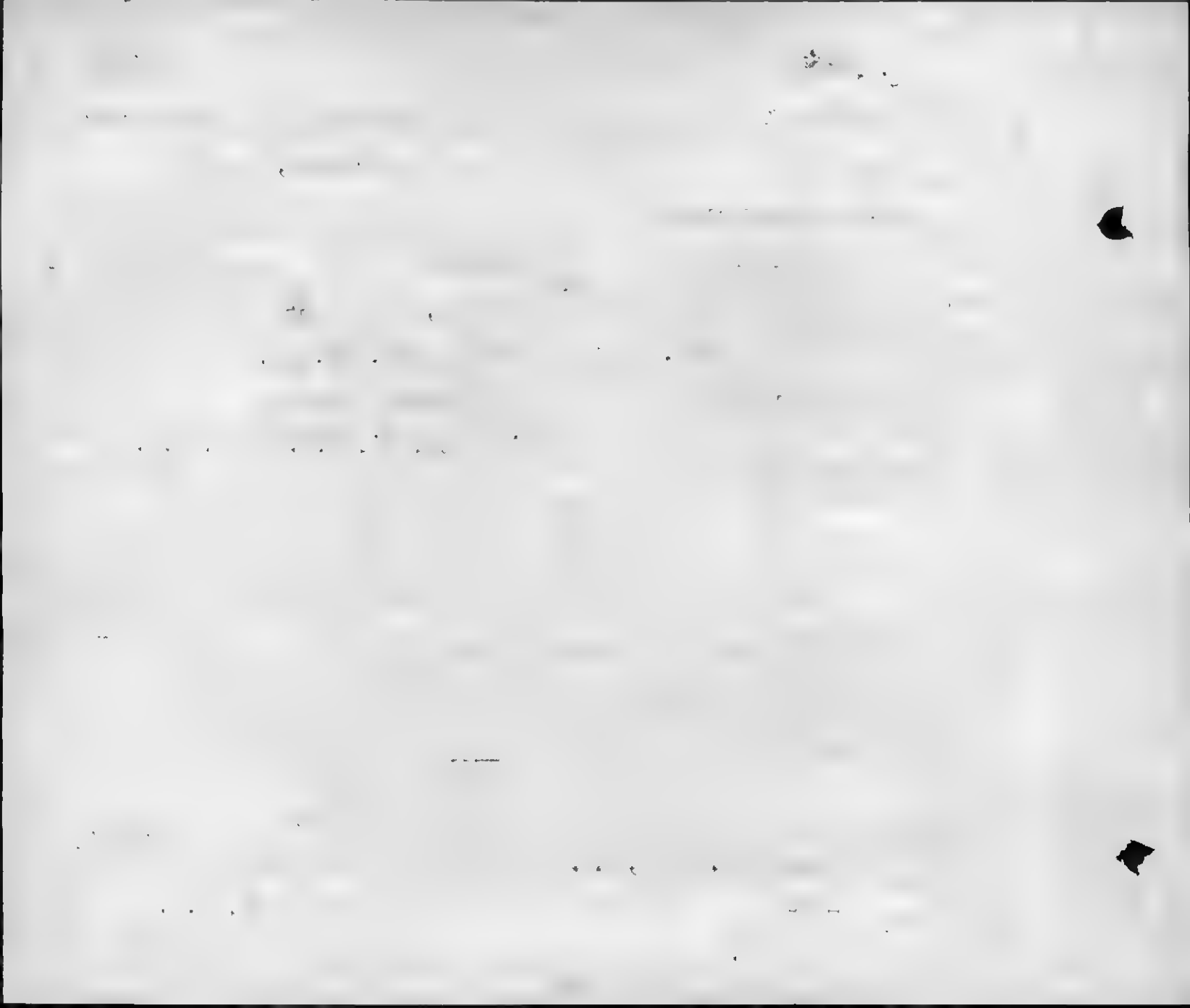
1 FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>10-71 Film 290 66601</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>CO150</div>											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY Anne Arundel				b. STATE Maryland				b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Odenton								Barbersville, Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
1126 Annapolis Road											
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
SAMUEL				RICHARDSON				January 16 19 61			
5. SEX				6. COLOR OR RACE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			
Male				Colored				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)				10. IF UNDER 1 YEAR: IF UNDER 24 HRS.			
June 10, 1905				55 yrs.				Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Chauffeur				Pvt. family				Prince Geo. Co. Md.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
USA				Patrick Richardson				Elizabeth Douglass			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. ADDRESS			
								Mr. George S. Richardson 3340 10th. St. N.W. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
716.6 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
Extensive 2nd and 3rd Degree Body Burns											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); 19. WAS AUTOPSY PERFORMED?											
acute alcoholism											
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
Fire in front House											
20c. TIME OF INJURY Month, Day, Year											
2:45 p.m. 1/16/61											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
House Odenton A. A. Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty											
EXAMINER'S NAME (Type) Charles S. Petty, M.D.											
DATE SIGNED 1/17/61											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
22b. DATE THEREOF 1-28-60											
22c. NAME OF CEMETERY OR CREMATORY Woodlawn											
22d. LOCATION (City, town, or country) (State) Washington, D.C.											
23. FUNERAL DIRECTOR Holland Funeral Home											
ADDRESS 1631 Druid Hill Ave.											
24a. REC'D BY REGISTRAR JAN 30 '61											
24b. REGISTRAR'S SIGNATURE Arthur S. Kline											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

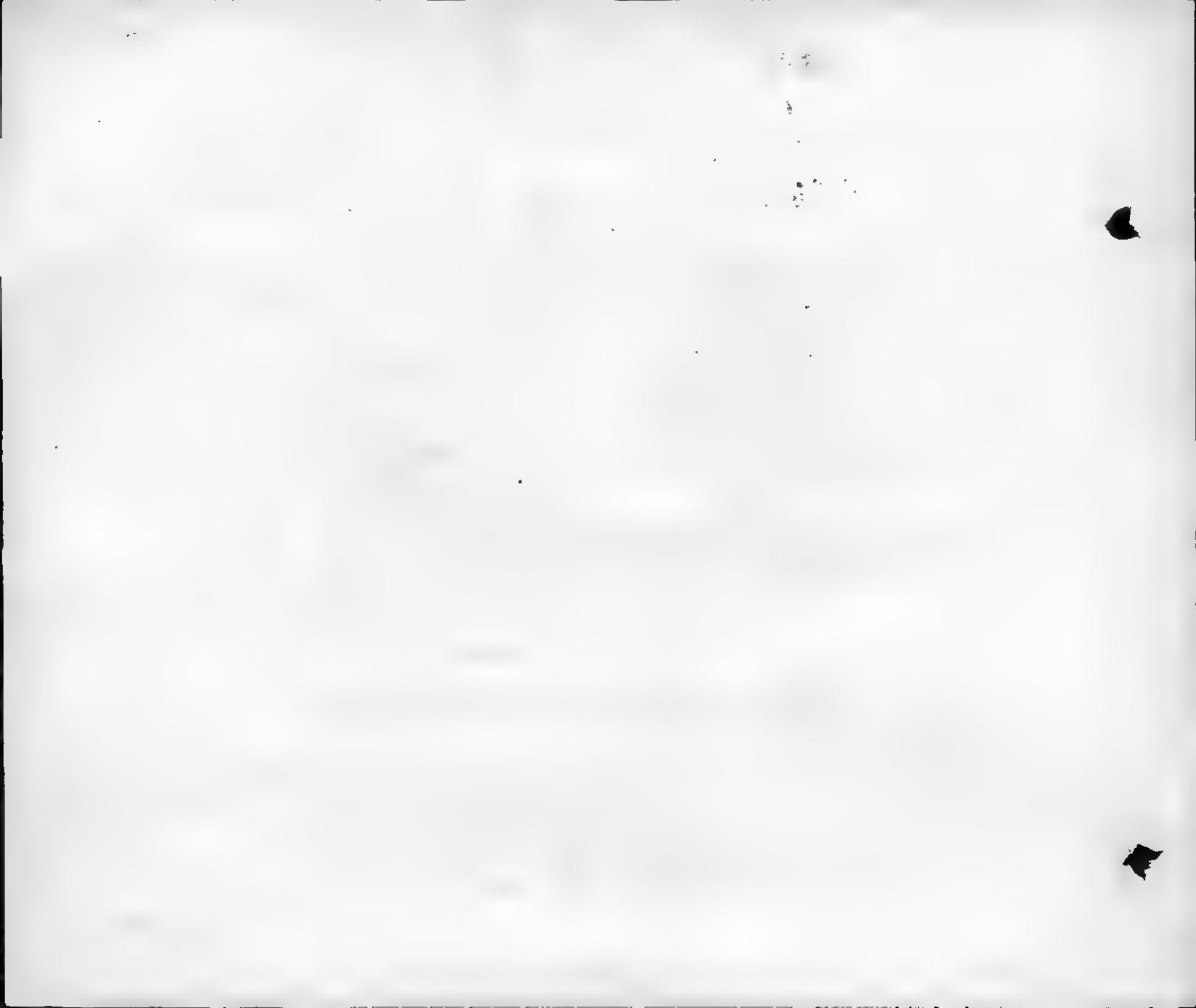
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

149

CERTIFICATE OF DEATH

00151

1 PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>General Hospital</i>		e. STREET ADDRESS <i>59 W. Washington</i>	
3 NAME OF DECEASED (Type or print) <i>Mildred</i> First Middle Last <i>Roberts</i>		4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-12-1922</i>
9 AGE (In years last birthday) <i>37</i> Yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Stanbury</i>		14. MOTHER'S MAIDEN NAME <i>Lola Arnold</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>William Stanbury, 59 Wash. St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO (b) <i>Brain</i> DUE TO (c) <i>Stroke</i> Conditions of any which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>12-22-60</i> 19 to <i>1-1-61</i> 19, that (I) (we) last saw the deceased alive on <i>12-31-60</i> 19, and that death occurred at <i>1</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William Reese</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-7-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		23d. LOCATION (City, town, or county) (State) <i>Skidmore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25. REC'D BY REGISTRAR <i>1</i> DATE JAN 9 '61	
25b. REG. STRAR'S SIGNATURE <i>Charles S. Thomas</i>			



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Tlien please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

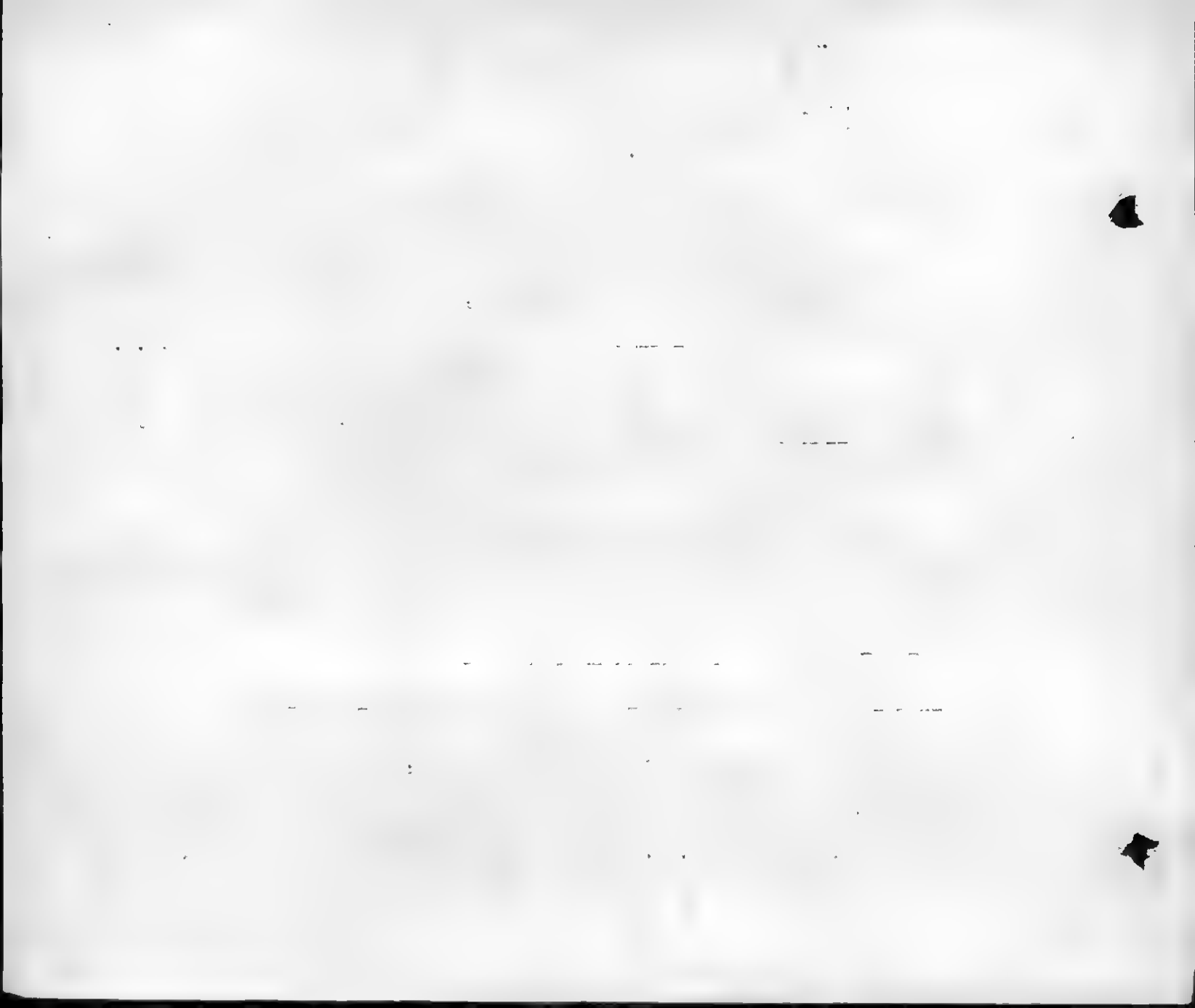
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00152

150

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 mos. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Gordy Middle Robinson Last Robinson		4. DATE OF DEATH Month 1 Day 11 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1893
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 67 Days 11 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/26 19 60 to 1/11/ 19 61 that (I) (we) last saw the deceased alive on 1/11 19 61 , and that death occurred at 4:20 PM, from the causes and on the date stated above			
22a. SIGNATURE L. Benedict, M. D.		22b. ADDRESS Crownsville State Hospital, Maryland	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/13/61	
23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City, town, or county) (State) Deal Island	
24. FUNERAL DIRECTOR'S SIGNATURE Charles H. Phillips		25a. REC'D BY REGISTRAR JAN 18 61	
25b. REGISTRAR'S SIGNATURE Conrad S. Thomas		25c. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0153

151

1. PLACE OF DEATH a. COUNTY <i>Ann Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Ann Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burke, Glen Burnie 4 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rd #1, Box 222 Pasadena, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Same</i>				d. STREET ADDRESS <i>Same</i>			
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>MAY V.</i> Last <i>Seaman</i>				4. DATE OF DEATH Month <i>Jan</i> Day <i>28</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 9, 1888</i>	
9. AGE (In years last birthday) <i>72</i> yrs		IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min <i>-</i>		IF UNDER 24 HRS Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min <i>-</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Silence</i>				14. MOTHER'S MAIDEN NAME <i>BETTA BOND</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-22-619</i>		17. INFORMANT <i>WALTER Seaman</i> Address <i>Rd #1 Box 222 Pasadena Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>151X</i> DUE TO <i>Pulmonary Metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gastric Carcinoma</i> (c) <i>Arterial Embolus, Popliteal, Right</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>6 weeks</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterial Embolus, Popliteal, Right</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>-</i> p. m. <i>-</i> 19 <i>61</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>61</i> to <i>7/28</i> 19 <i>61</i> , that (I) was lost saw the deceased alive on <i>1/28</i> 19 <i>61</i> and that death occurred at <i>8:30</i> P. M. from the causes and on the date stated above							
22a. SIGNATURE <i>Dr. Richard</i>				22b. DATE SIGNED <i>7/28</i>			
22c. PHYSICIAN'S NAME (Type) <i>A. W. PRICHARD M.D.</i>				22d. ADDRESS <i>Glen Burnie, Md</i>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/31/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore 25, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>				25a. REC'D BY REGISTRAR <i>Feb 1 '61</i>		25b. REGISTRAR'S SIGNATURE <i>William R. Hume</i>	

I



FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>3/12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Linda Lane</u>		d. STREET ADDRESS <u>Same</u> <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>George A. Shaw</u>		4. DATE OF DEATH <u>Jan 19 1961</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 /14/95</u>
9. AGE (in years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Nora Roach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>206-07-5211</u>	
17. INFORMANT <u>Major James McManus (Son-In-Law)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert MD</u>		DATE SIGNED <u>1/19/61</u>	
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>20th Jan. '61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Louis Cath. Ch. Cem.</u>	22d. LOCATION (City, town, or county) <u>Limestone, Maine</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Christina S. K...</u>

This certificate should be filed within 24 hours after death. If any delay is necessary, please call the State Health Department. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

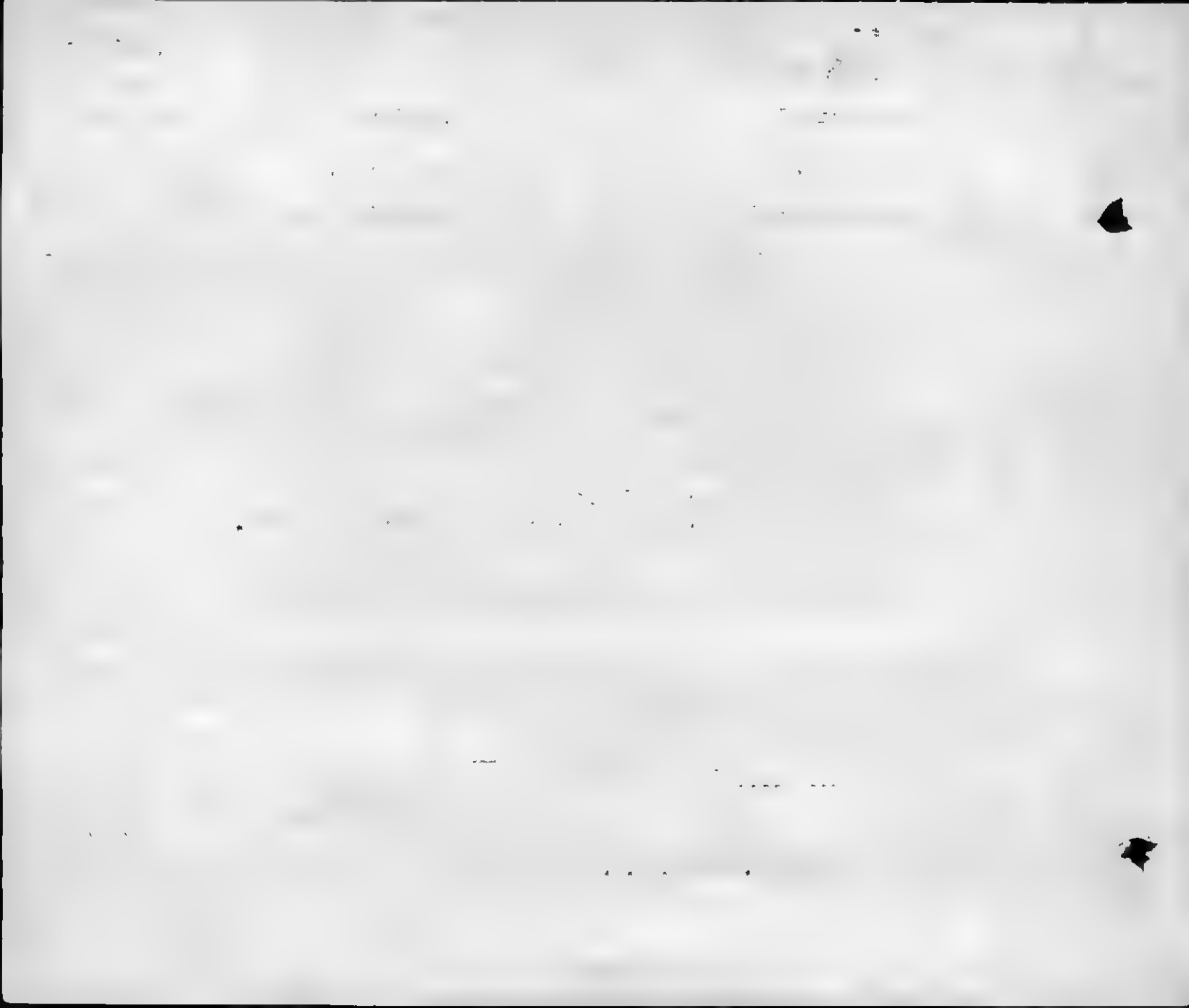


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Anne Arundel				a. STATE Maryland			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) West River				b. COUNTY Anne Arundel			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shadyside Road				d. STREET ADDRESS Shadyside Road			
3. NAME OF DECEASED (Type or print) WILLIAM WOLFORD SHINNICK				4. DATE OF DEATH January 27 19 61			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH MARCH 14, 1893			
9. AGE (In years, last birthday) 67 yrs.				10. AGE (In years, last birthday) 67 yrs.			
11. BIRTHPLACE (State or foreign country) Baltimore Md				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ORMSBY SHINNICK				14. MOTHER'S MAIDEN NAME Martin Jane Eskridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 183-01-3240			
17. INFORMANT MINNA L SHINNICK				Address Chalk Point, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-1							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19							
20d. INJURY OCCURRED While at work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
DATE SIGNED 1/28/61							
ACTUAL SIGNATURE Charles S. Petty M.D.							
EXAMINER'S NAME (Type) Charles S. Petty, M.D.							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF JAN 31, 1961							
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY							
22d. LOCATION (City, town, or county) (State) BALTIMORE MD							
23. FUNERAL DIRECTOR T A Hardesty & Son							
ADDRESS Galeville, Md							
24a. REC'D BY REGISTRAR FEB 1 '61							
24b. REGISTRAR'S SIGNATURE U. L. L. L.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

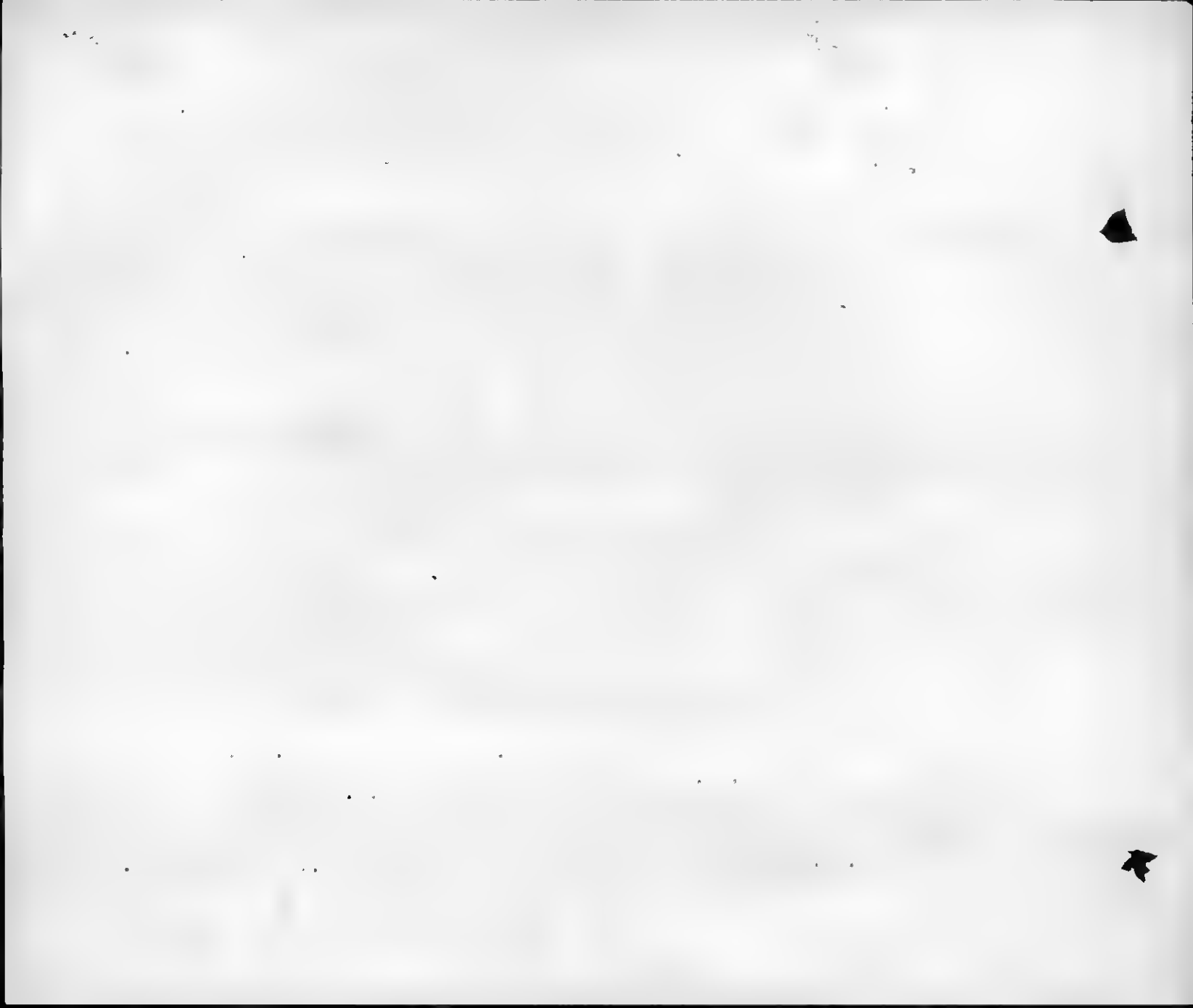
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

154

00082

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Eliza SIMMS				4. DATE OF DEATH Month Day Year January 10 19 61			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 1, 1906		9. AGE (In years last birthday) 54 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Raymond Barker Tobacco Farmer				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Joe Simms Harwood - Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO (b) Hypertensive cardiac vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Dissecting aortic aneurysm							INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan. 8, 19 61 to Jan. 10, 19 61 that (I) (we) last saw the deceased alive on Jan. 9, 19 61 and that death occurred at 4:00 A.M. from the causes and on the date stated above							
22a. SIGNATURE A. T. Allen				22b. DATE SIGNED 1/10/61		22c. PHYSICIAN'S NAME (Type) A. T. Allen	
22d. ADDRESS 62 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-14-61		23c. NAME OF CEMETERY OR CREMATORY Chews Chapel		23d. LOCATION (City, town, or county) (State) West River, Md	
24. FUNERAL DIRECTOR'S SIGNATURE TA Hardesty & Son				25a. REC'D BY REGISTRAR DATE FEB 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst'ted on: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>912 Smithfield Street</i>		d. STREET ADDRESS <i>912 Smithfield</i>	
3. NAME OF DECEASED (Type or print) <i>Jamie</i> First <i>Snowden</i> Middle <i>Snowden</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-10-1887</i> yrs. <i>73</i>
9. AGE (In years last birthday) <i>73</i>		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>6</i> IF UNDER 24 HRS. Hours <i>1</i> Min. <i>6</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herbert Parker</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Brandford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>George Snowden 69 N. West St.</i>	
17. INFORMANT <i>George Snowden</i>		Address <i>69 N. West St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sudden</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William Reese</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. M. H.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>1-6-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-10-1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>11 '61</i>		24b. REGISTRAR'S SIGNATURE <i>James L. Frank</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

156 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00157

Items 8, 9, 11, 12 Will G279 1-16-61 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis-MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis-10</u>	
c. LENGTH OF STAY IN 1b —		d. STREET ADDRESS <u>Box 422 - Rt 2 - Ch. Annapolis - Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL J. GUYER & L</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1961</u>	
3. NAME OF DECEASED (Type or print) <u>DARNEIL</u>	First <u>DARNEIL</u> Middle <u>K</u> Last <u>Sommerville</u>	5. AGE (in years last birthday) <u>1</u> yrs	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>1</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Sommerville</u>		14. MOTHER'S MAIDEN NAME <u>Odean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John W. Sommerville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1-2-3rd degree Burns</u> <u>9160C</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Lure at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:30 p.m. 1-7 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>HACD MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 10 1961</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver's Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Jones Bluff A.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold J. Johnson</u>		24a. REC'D BY REGISTRAR <u>JAN 10 61</u>	
ADDRESS <u>Annapolis</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Haines</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66158

1. PLACE OF DEATH
a. COUNTY A.A. Co. MARYLAND
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) ANNEAPOLIS - MD.
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ANNE ARUNDEL GENERAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD b. COUNTY A.A. Co.
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) ANNEAPOLIS
d. STREET ADDRESS Box 422 - 422 - 2nd St. - Baltimore

3. NAME OF DECEASED (Type or print) First Middle Last
MARY Louise Sommerville.

4. DATE OF DEATH Month Day Year
1 8 1961

5. SEX F 6. COLOR OR RACE C 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH APR 13/58

9. AGE (In years) 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore City, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Sommerville 14. MOTHER'S MAIDEN NAME Olsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT John W. Sommerville Address John's Station

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1-2-3rd degree Burn
DUE TO 916.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fall at home

20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 1-7 1961 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) ANNEAPOLIS MD

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE E. Linhardt. M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 1/8/61

NAME (Type) E. Linhardt. Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 18 1961 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY Carpenter's Hill 22d. LOCATION (City, town, or county) (State) Jones Station, A.A. Co.

23. FUNERAL DIRECTOR Arnold A. Johnson ADDRESS Annapolis 24a. REC'D BY REG STRAR JAN 10 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Frame



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

158

CERTIFICATE OF DEATH

Reg. Dist. No.

01484

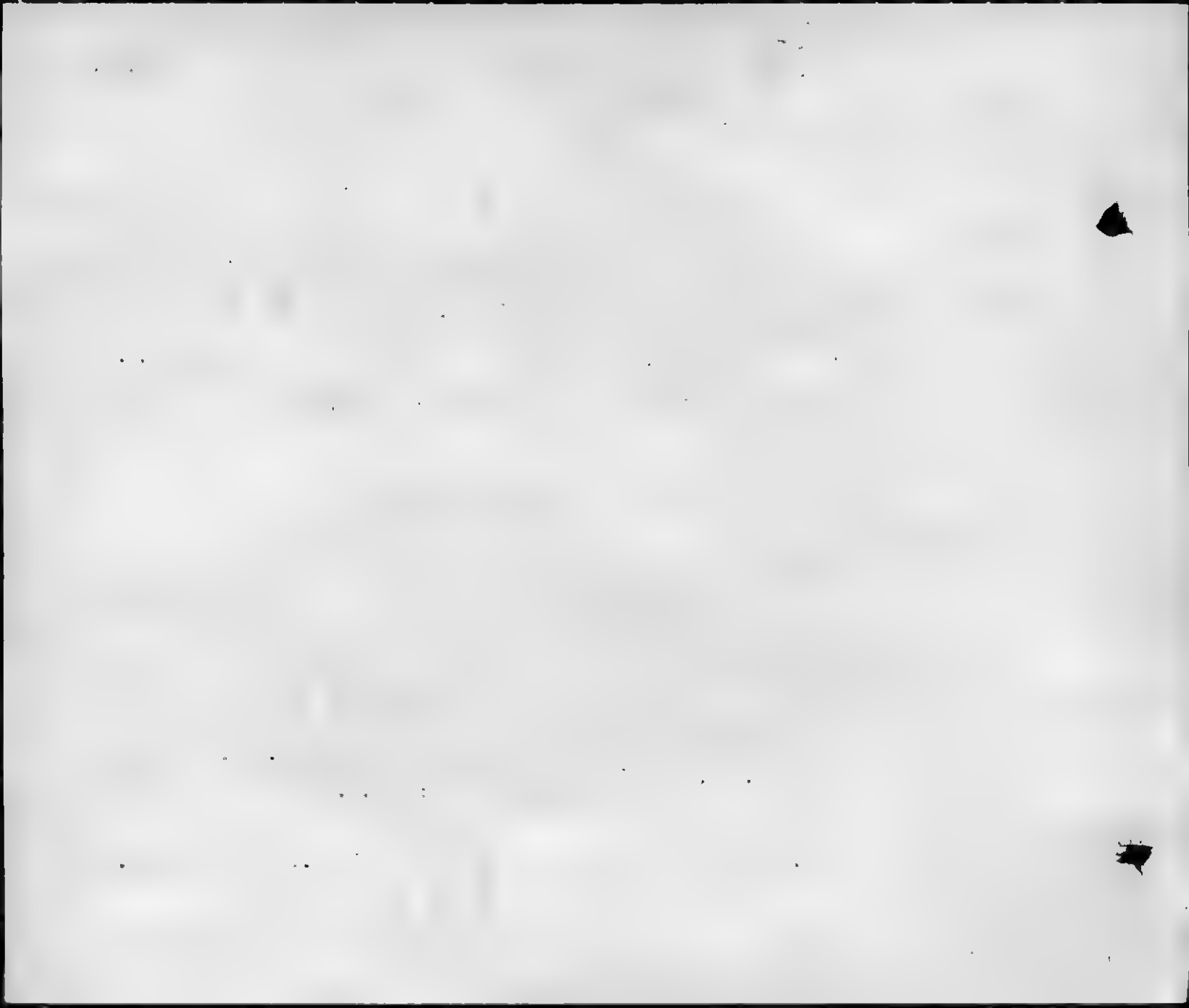
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>258 WEST ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>DECEASED</u> (Type or print) First <u>IDELLA</u> Middle <u>SWEENEY</u> Last <u>SWEENEY</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/88</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>HWF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>PRINCE GEORGE CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SIMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH PEACOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Annapolis, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac. Heart Failure</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1956, to <u>Jan 27</u> , 1961, that I last saw the deceased alive on <u>Dec 16</u> , 1961, and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klamans</u> M.D.		DATE SIGNED <u>1/27/61</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAMANS</u>		ADDRESS (Street, city or town, state) <u>31 Southgate Ln Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/30/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home—Upper Marlboro,</u>		24a. REC'D BY REGISTRAR <u>1 A '61</u>	
ADDRESS <u>Id.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Arthur L. French

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

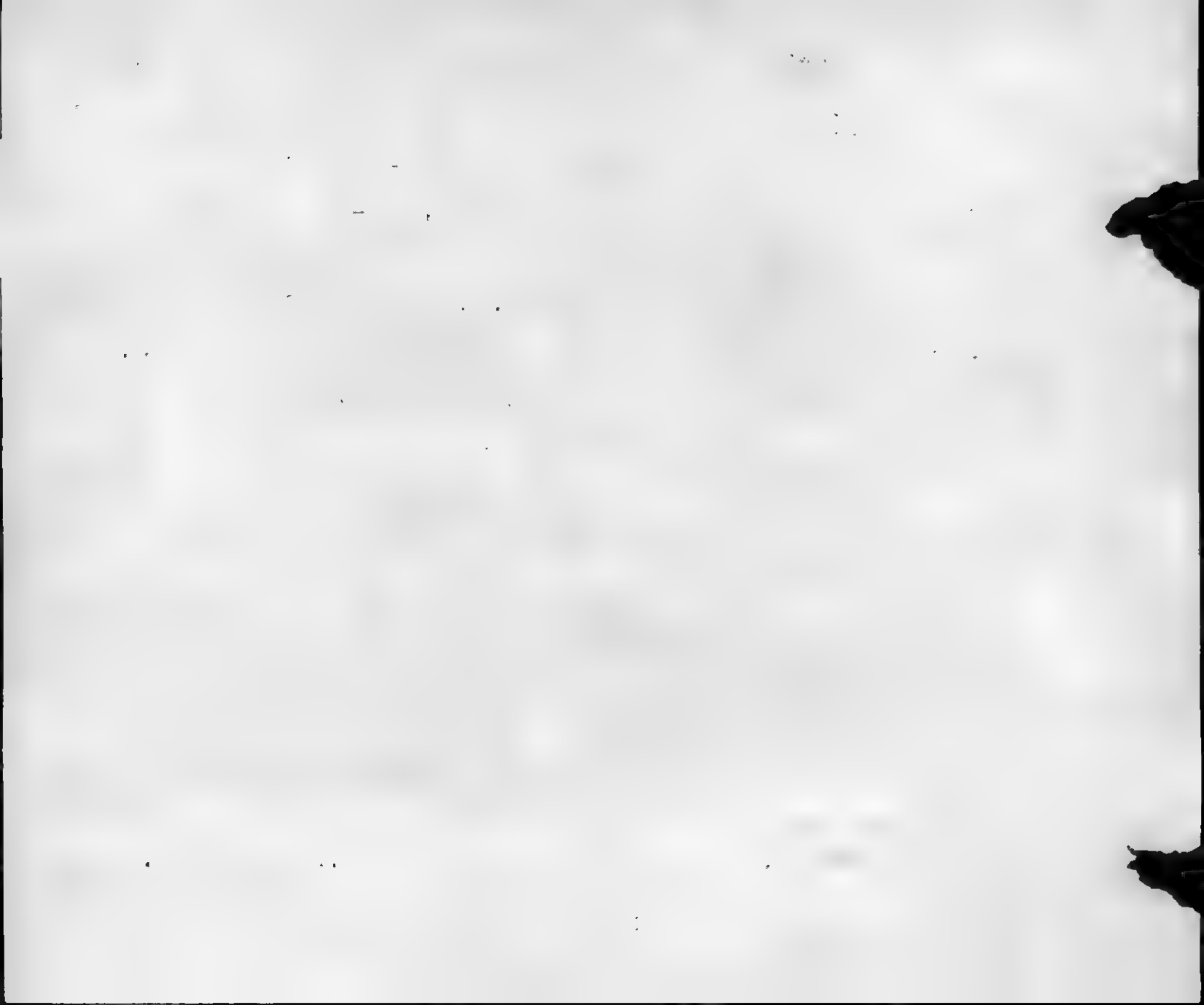
160

00160

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis d. STREET ADDRESS Rt-2, Box-347	
3. NAME OF DECEASED (Type or print) Theret (THERROTIE) T. TAYLOR		4. DATE OF DEATH Month January Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGRONOMIST		10b. KIND OF BUSINESS OR INDUSTRY U.S GOLF ASSO	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN T. TAYLOR		14. MOTHER'S MAIDEN NAME MARTHA BISHOP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 097-01-565		16. SOCIAL SECURITY NO. 097-01-565	
17. INFORMANT EVALYN R. TAYLOR		Address 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 464 X DUE TO Conditions, if any, which gave rise to immediate cause (b) THROMBOPHLEBITIS RT. ILLIAC VEIN (c) 5 DAYS causing the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA PANCREAS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the informant) attended the deceased from 1-18-1961 to 1-24-1961 , that (I) (the informant) saw the deceased alive on 1-24-1961 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck 22b. PHYSICIAN'S NAME (Type) Edward S. Beck		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 71 Franklin St., Annapolis, Md.	
22b. DATE SIGNED 1/24/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-27-1961	23c. NAME OF CEMETERY OR CREMATORY White Hall Cent	23d. LOCATION (City, town or county) (State) St Marguerite QAC Md
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Son		25a. REC'D BY REGISTRAR JAN 30 '61	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The attending physician or hospital or attending physician must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



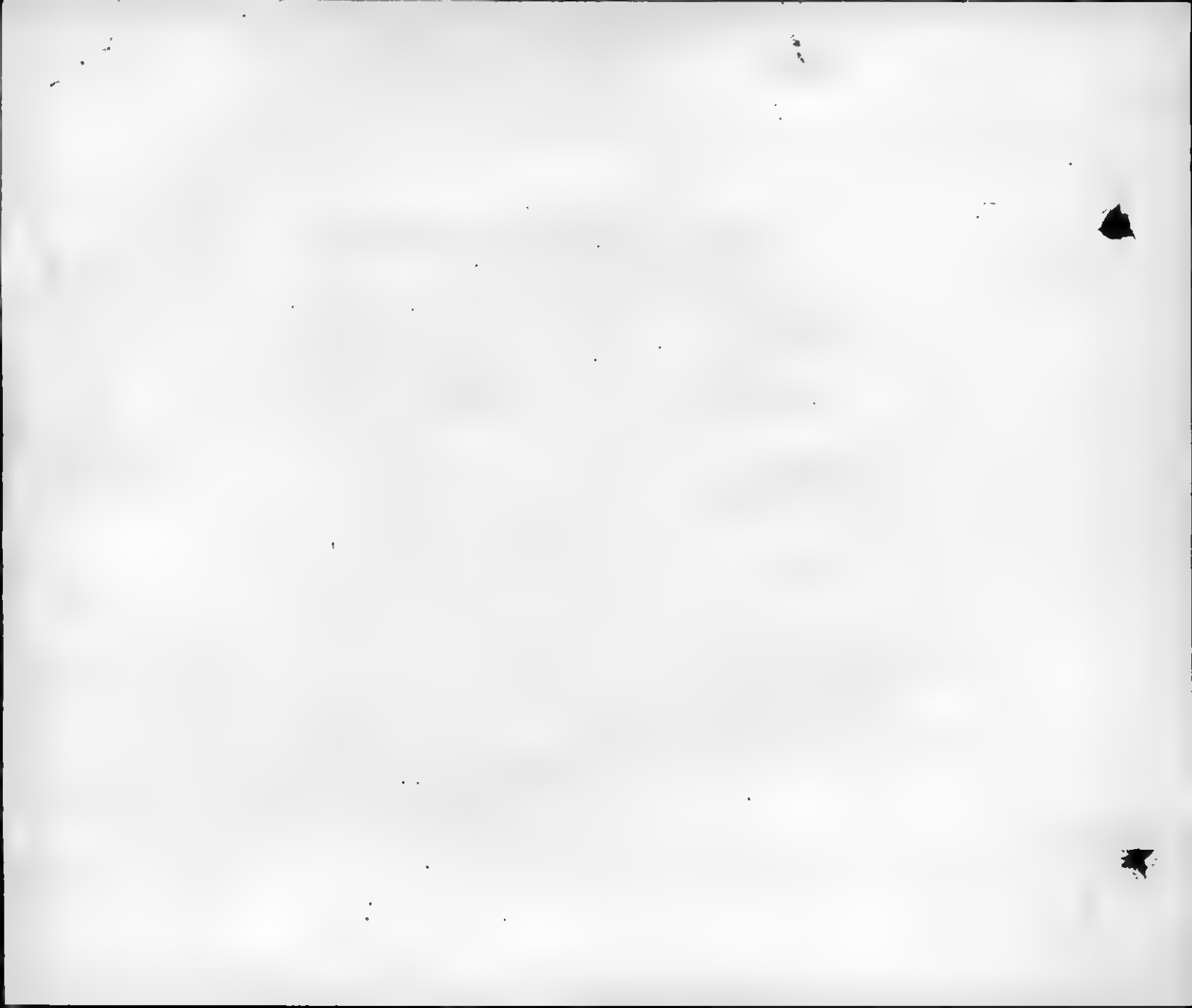
may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

C0161

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY A. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hts.				c. LENGTH OF STAY IN 1b 44 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Hammonds Ferry Road - North				e. STREET ADDRESS 315 Hammonds Ferry Rd. North			
3. NAME OF DECEASED (Type or print) First Estella Middle M. Last Towson				4. DATE OF DEATH Month Jan Day 1 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10 1893	
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Balte, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Holtritter				14. MOTHER'S MAIDEN NAME Mary - (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 216-18-3807			
17. INFORMANT Mrs. Ross Tordon - Same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma (adenocarcinoma) of Stomach and Intestine DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 27, 1960 to January 1, 1961 , that (I) just last saw the deceased alive on January 1, 1961 , and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE E. Rodenick Shipkey				22b. DATE January 3, 1961		22c. PHYSICIAN'S NAME (Type) E. Rodenick Shipkey M.D.	
22d. ADDRESS 529 Camp Meade Rd., Linthicum Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4 - 61		23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery Balte		23d. LOCATION (City, town, or county) (State) md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert P. Moore				25a. REC'D BY REGISTRAR DATE JAN 5 '61		25b. REGISTRAR'S SIGNATURE John S. Moore	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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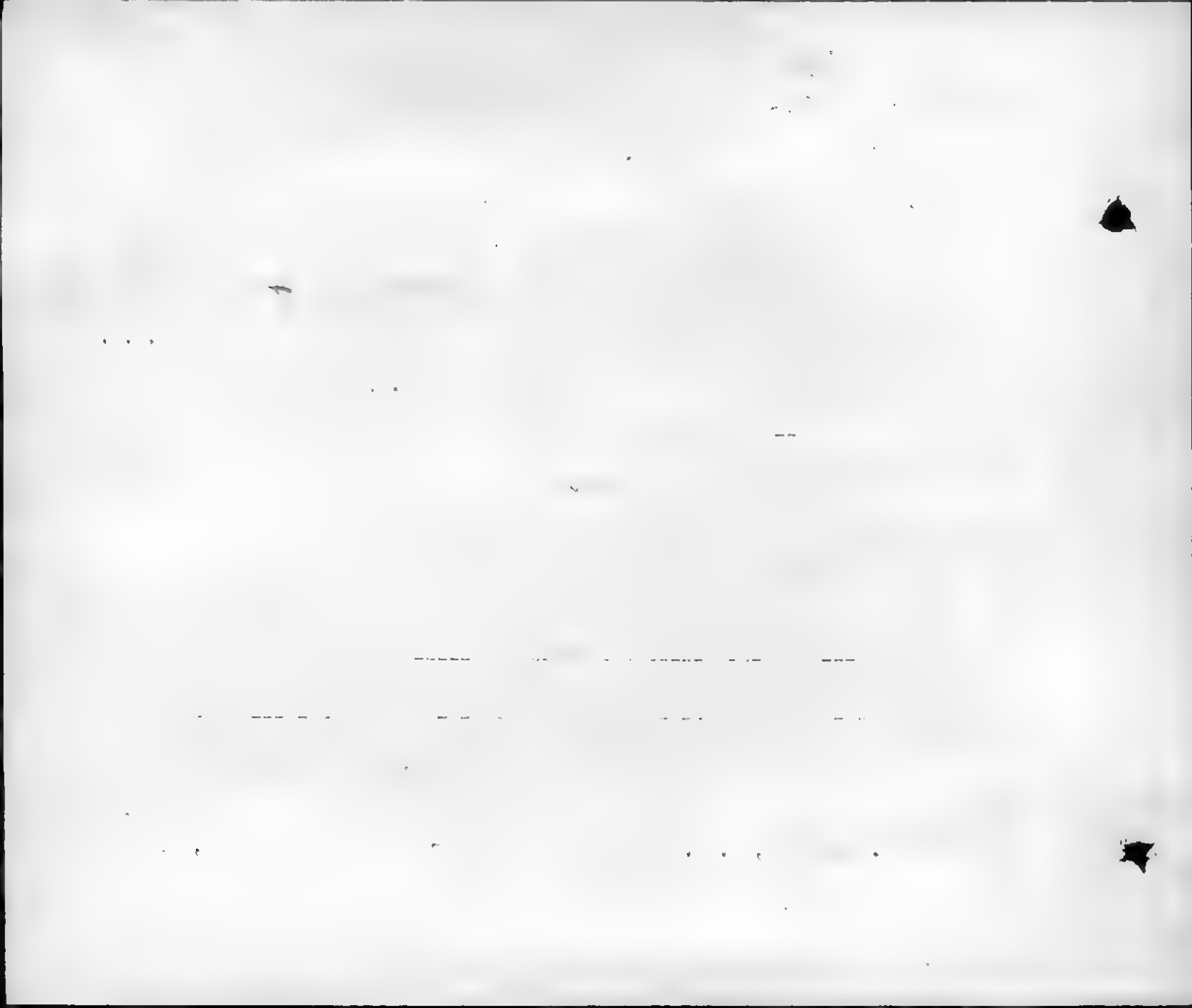
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00162

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mos. 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3834 Eagle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Last Tripps		4. DATE OF DEATH Month 1 Day 3 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1893 9. AGE 67 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Tripps		14. MOTHER'S MAIDEN NAME Francis J. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 11/11/60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 60 1/3/ 61	
21. I certify that (I) (this hospital) attended the deceased from 11/11/60 to 1/3/61 , that (I) (we) last saw the deceased alive on 1/3/61 , and that death occurred at AM , from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED January 3, 1961 M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL CREMATATION, REMOVAL (Specify) 1-7-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Not given		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. McNamee		25a. REC'D BY REGISTRAR Jan 5 '61 DATE	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



the funeral director, should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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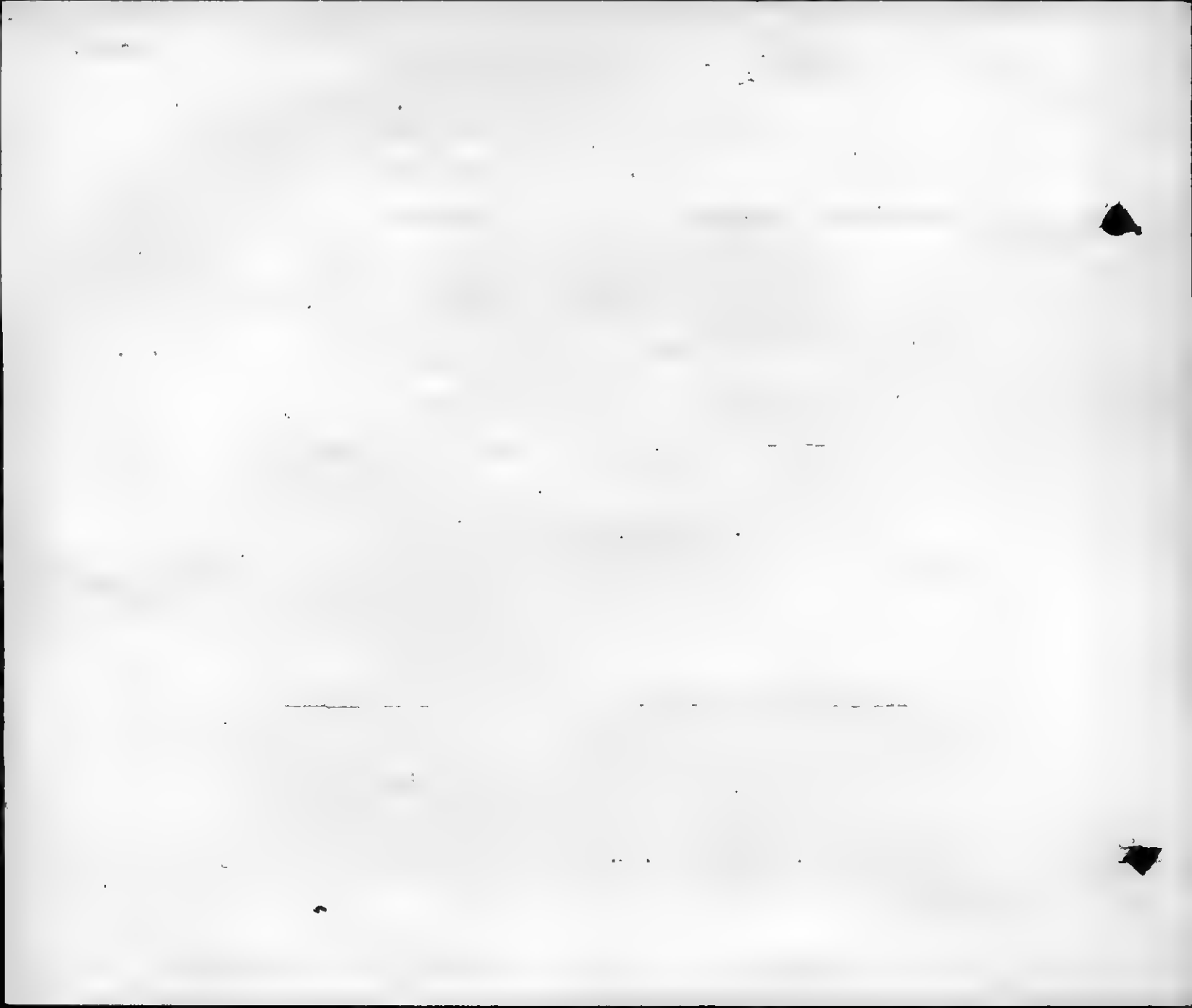
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00163

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 years 5 mos. 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Camp Parole		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Tyler Last Tyler				4. DATE OF DEATH Month 1 Day 8 Year 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-1899		9. A. 62 years (today) yrs	IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition & Dehydration DUE TO Chronic Brain Syndrome Associated with Central Nervous System Syphilis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome Associated with Central Nervous System Syphilis (c) Chronic Brain Syndrome Associated with Central Nervous System Syphilis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/29 1949, to 1/8 1961, that (I) (we) last saw the deceased alive on 1/8 1961, and that death occurred at 6:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/9/61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-61		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR JAN 11 '61	
				25b. REGISTRAR'S SIGNATURE <i>William L. Reese</i>			



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00170

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pathe Highway & Earle Rd</u>				d. STREET ADDRESS <u>Pathe Highway & Earle Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Frank Anthony Wagner</u>				4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26, 1893</u>		9. AGE (in years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Frank A. Wagner</u>			
14. MOTHER'S MAIDEN NAME <u>Hartlove</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Halter wife</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> <u>180X</u> DUE TO (b) <u>Carcinoma of Kidney</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>			
20h. (State) <u> </u>				20i. (Country) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12-30-1961</u> and that death occurred at <u>3 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Robert R. Halpin</u>				22b. DATE SIGNED <u>1-24-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert R. HALPIN</u>	
22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>1-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

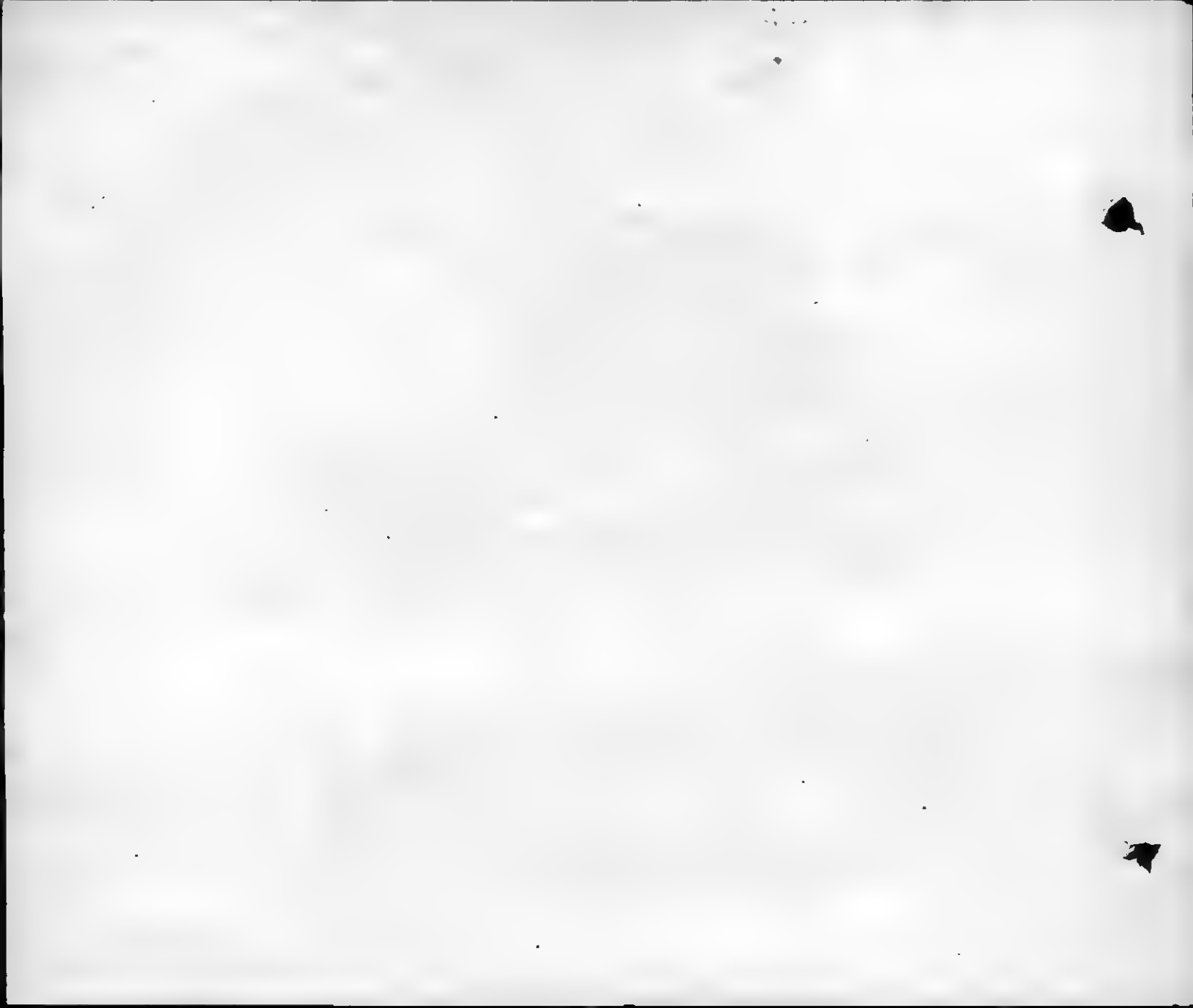
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, and in any event, within 72 hours after death.
the State Board of Health prior to burial, cremation, or removal.

VR A15 (4)
15M 11/59

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00164

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Crownsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Pauline</i> Middle <i>E.</i> Last <i>Walston</i>		4. DATE OF DEATH Month <i>1</i> Day <i>13</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar-31-1914</i>
9. AGE (In years last birthday) <i>46</i> yrs		IF UNDER 1 YEAR Months <i>4</i> Days <i>6</i>	IF UNDER 24 HRS Hours <i>18</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wilmington N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Bertina Garganus</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1-17-1961</i>	
17. INFORMANT <i>William C. Walston</i>		Address <i>Wilmington N.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] -PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrenous small bowel</i> DUE TO (b) <i>Thrombosis superior mesenteric artery</i> DUE TO (c) <i>Arteriosclerosis of aorta</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>18 hr.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mild arteriosclerosis + nephrosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-13-61</i> to <i>1-13-61</i> that (I) (we) last saw the deceased alive on <i>1-13-61</i> , and that death occurred at <i>1-13-61</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Frank M Shipley</i>		22b. DATE SIGNED <i>1-14-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		22d. ADDRESS <i>Annapolis, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>1-17-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Garbors N.C.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sr</i>		25a. REC'D BY REG STRAR <i>JAN 16 '61</i>	
ADDRESS <i>Annapolis Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



CERTIFICATE OF DEATH

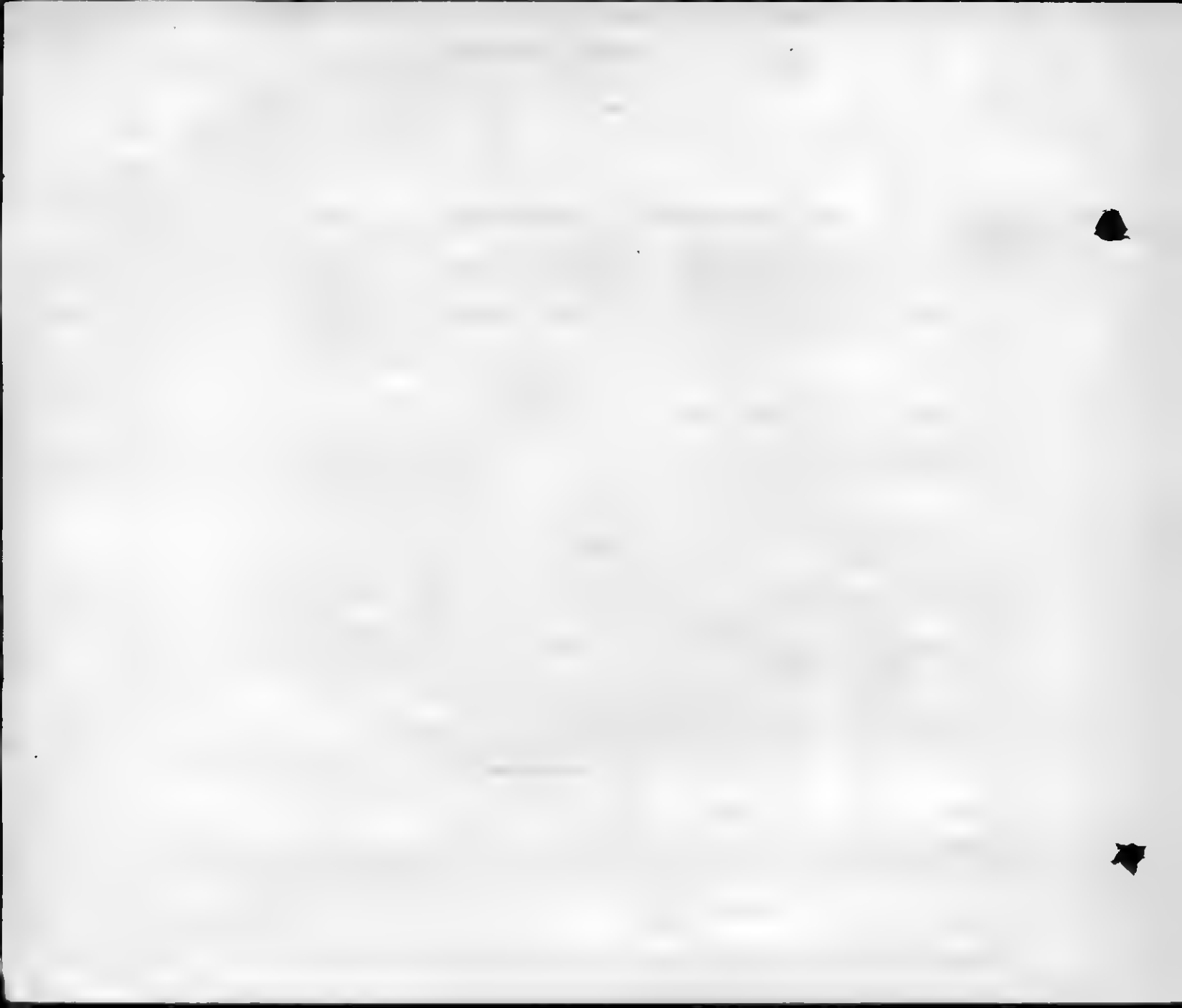
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Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <u>DC</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>E.</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Higgs</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Ward</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Charles Ward</u>		17. INFORMANT <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic obstructive pulmonary disease</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic obstructive pulmonary disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan 9</u> , 19 <u>61</u> to <u>Jan 9</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>61</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis Md.</u> DATE SIGNED <u>John H. Hedeman</u>			
21. ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D.				22. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-14-1961</u>		22c. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hedeman</u>				24a. REC'D BY REGISTRAR <u>Charles E. Haines</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



167

CERTIFICATE OF DEATH

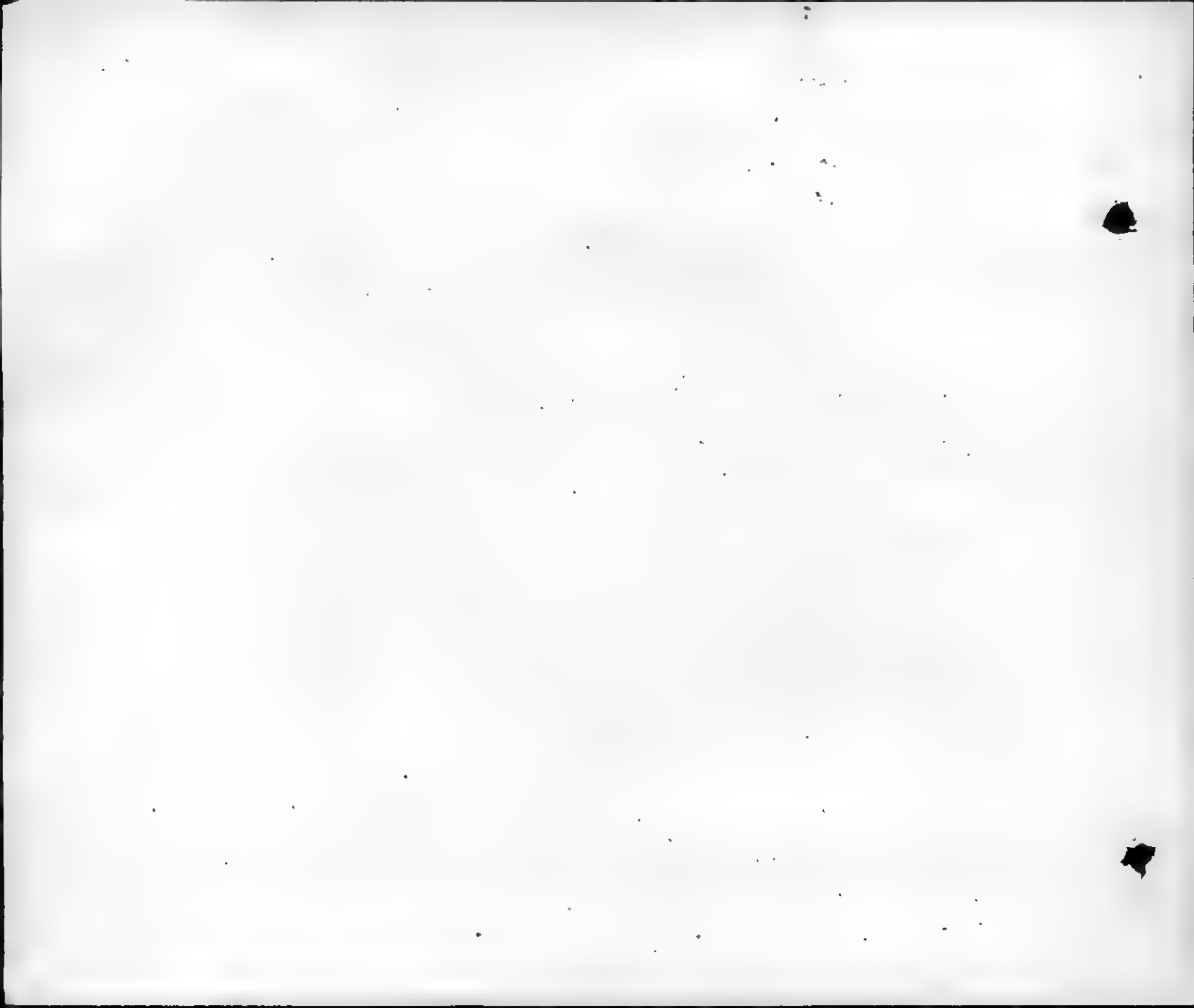
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk River MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs</u>		d. STREET ADDRESS <u>1 Rt 1 - Box 71</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie D. Webb</u>		4. DATE OF DEATH <u>Jan 2 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23-1894</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR	10. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>		13. FATHER'S NAME <u>Andrew D. Dunsen</u>	
14. MOTHER'S MAIDEN NAME <u>Hannah O. Wayfield</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> 1577X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		DATE SIGNED <u>Jan 4 1961</u>	
PHYSICIAN'S NAME (Type) <u>J. Brady Smith</u>		Address <u>Pasadena, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 5-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elk River</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald A. Frank</u> ADDRESS <u>Elk River MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

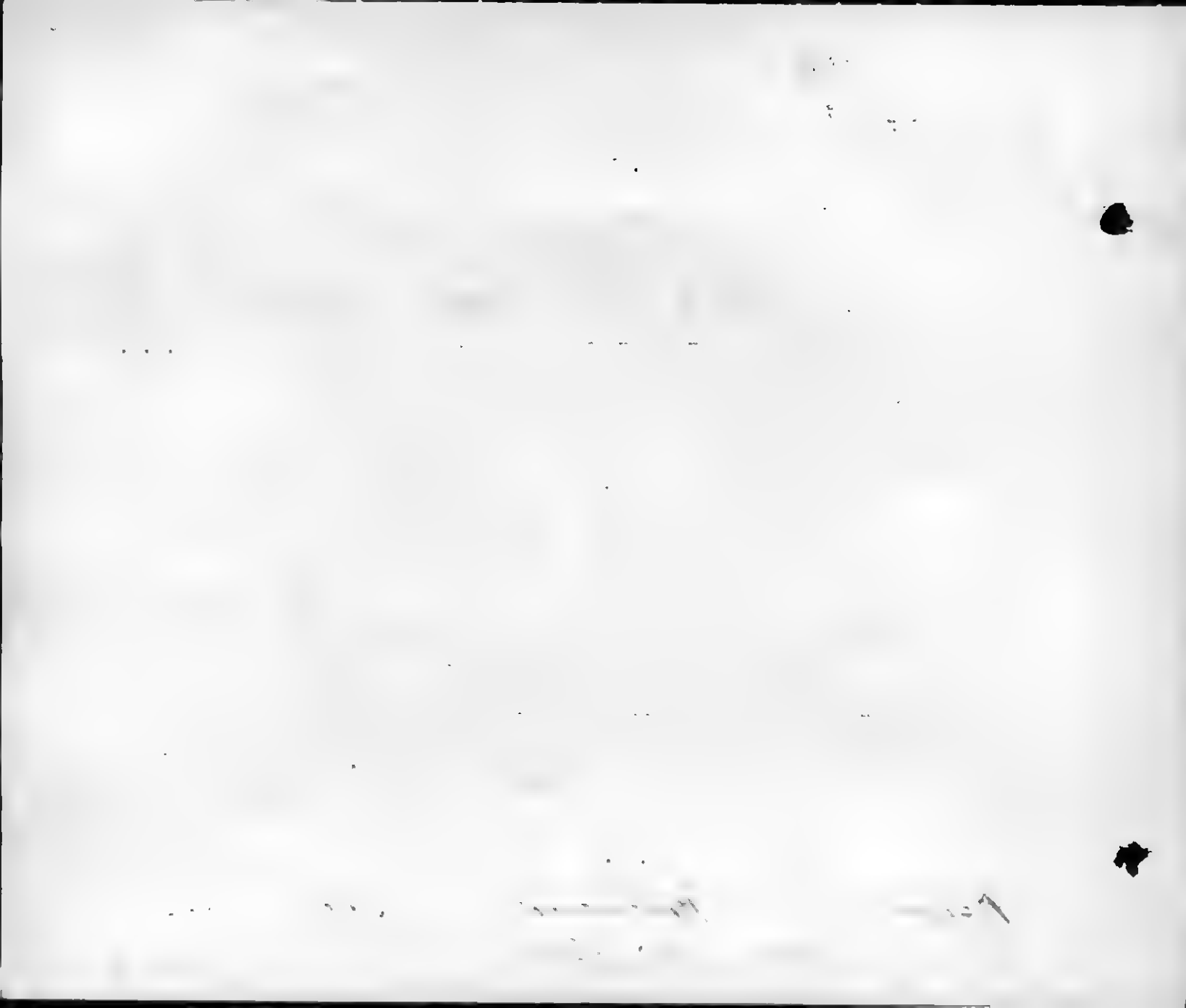
Reg. Dist. No.

00088

168

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 31 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center				d. STREET ADDRESS 1610 Gales Street N.E.			
3. NAME OF DECEASED (Type or print) First John Middle Robert Last Weil				4. DATE OF DEATH Month January Day 30 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1898	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized				10b. KIND OF BUSINESS OR INDUSTRY unknown			
11. BIRTHPLACE (State or foreign country) unknown				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Fred Weil				14. MOTHER'S MAIDEN NAME Emma Weil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Children's Center, Laurel, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO 440X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental retardation							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-27-1961 to 1-30-1961 , that I last saw the deceased alive on 1-30-1961 , and that death occurred at 5:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen W. Dejter M.D.				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 1/31/61			
PHYSICIAN'S NAME (Type) Stephen W. Dejter				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 1/31/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 2, 1961			
22c. NAME OF CEMETERY OR CREMATORY District Training School				22d. LOCATION (City, town, or county) Laurel, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hovell, Jr. DTS Laurel, Md.				24a. REC'D BY REGISTRAR DATE FEB 8 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hovell			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

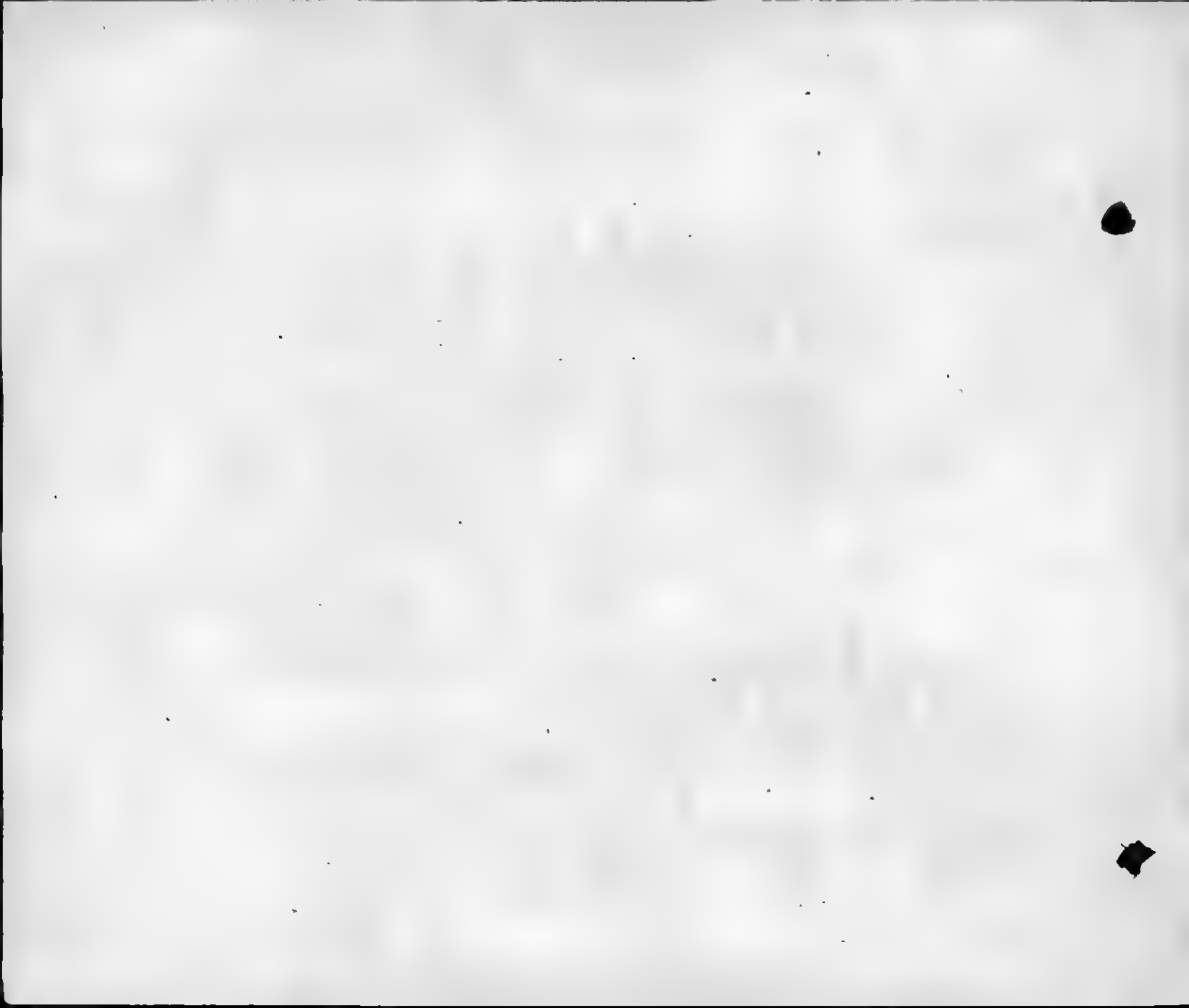
C0168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL <small>or give nearest town</small>) ANNAPOLIS		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. A. GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
		d. STREET ADDRESS 108 TOLSON ST. 1	
3. NAME OF DECEASED (Type or print) JOAN First CAROL Middle WHEELER Last		4. DATE OF DEATH Month JAN Day 31 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23 1932
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BACTERIOLOGIST		10b. KIND OF BUSINESS OR INDUSTRY MD STATE DEPT HEALTH ANNAPOLIS MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED W. WHEELER		14. MOTHER'S MAIDEN NAME A. JEANNE TYDINGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT ALFRED W. WHEELER		Address # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident	
20c. TIME OF INJURY Month, Day, Year Hour 1:30 p. m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) BALCO MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. L. IN HAND		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. L. IN HAND		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 4, 1961	
22c. NAME OF CEMETERY OR CREMATORY HILLCREST		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR, Sons ANNAPOLIS MD		24a. REC'D BY REGISTRAR DATE FEB 6 '61	
		24b. REGISTRAR'S SIGNATURE C. H. H. H.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.



FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, the certificate should be executed by the District Medical Director. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Maryland
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN It 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS Jones Station

a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) ROSAMAE H. WILSON
First Last Middle

4. DATE OF DEATH January 14, 1961
Month Day Year

5. SEX Female **6. COLOR OR RACE** Colored **7. MARRIED** ☒ **NEVER MARRIED** ☐ **8. DATE OF BIRTH** 5-22-1932
Month Day Year

9. AGE (In years last birthday) 28 yrs. **10. BIRTHPLACE** (State or foreign country) Maryland
Months Days Hours Min.

11. CITIZEN OF WHAT COUNTRY? U.S.A.

12. FATHER'S NAME Robert Williamson **13. MOTHER'S MAIDEN NAME** Emma Hunt

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No **15. SOCIAL SECURITY NO.** James Wilson 9 Pinkney St.
(If yes, give number and dates of service)

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Transection of cervical spine
DUE TO 812X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 812X DUE TO (c) 812X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARTIAL

17. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

18. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. **19. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto

20c. TIME OF INJURY Month, Day, Year 10:05 p.m. 1/14/61 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☒ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) Road **20f. (City or town)** Anne Arundel Md. (County) (State)

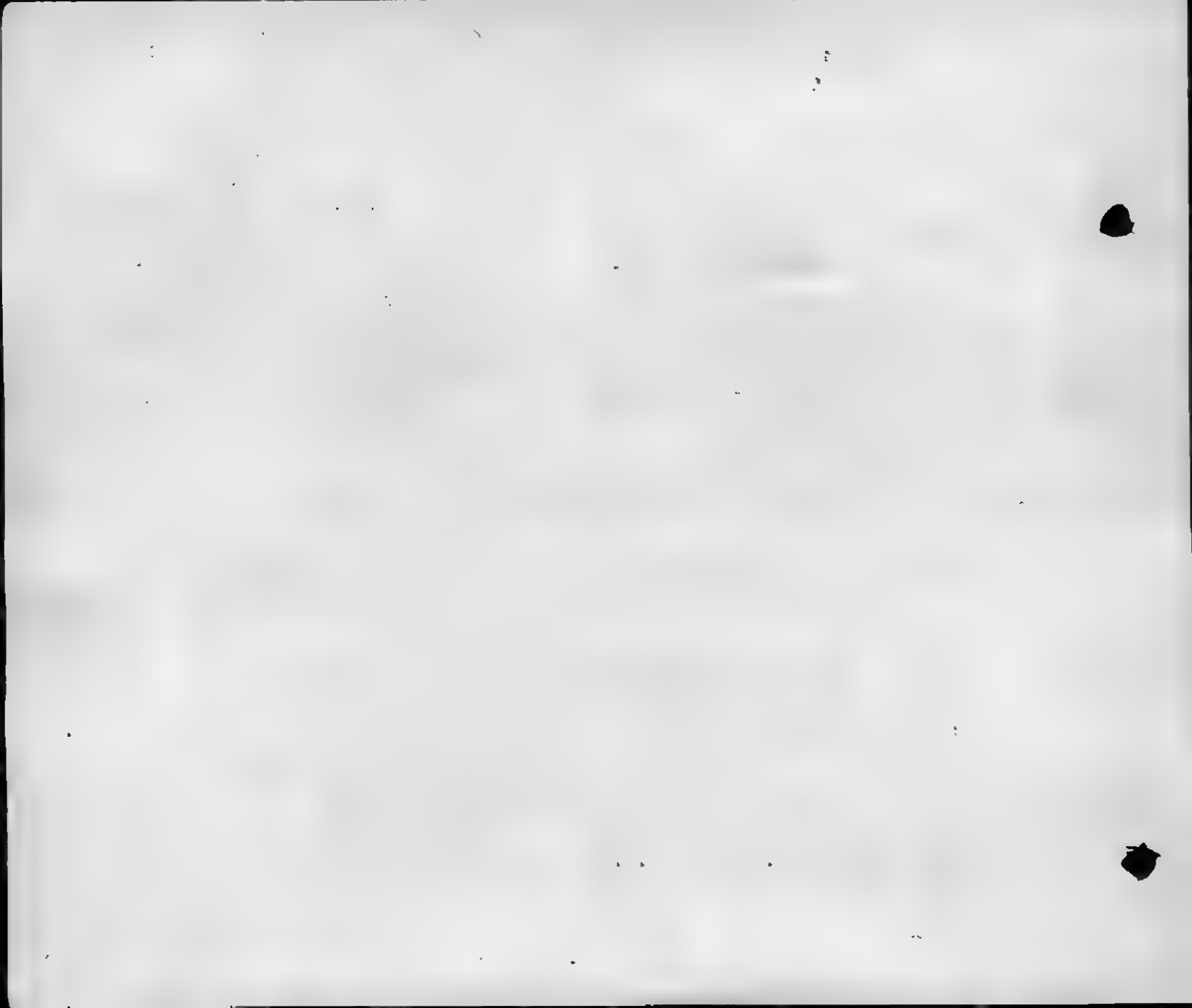
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher **CHIEF MEDICAL EXAMINER** ☒ **ASSISTANT MEDICAL EXAMINER** ☐ **DEPUTY MEDICAL EXAMINER** ☐ **DATE SIGNED** 1/16/61

EXAMINER'S NAME (Type) Russell S. Fisher, M.D. **Address** (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial **22b. DATE THEREOF** 1-20-61 **22c. NAME OF CEMETERY OR CREMATORY** St. Marys **22d. LOCATION** (City, town, or country) Annapolis Md. (State)

FUNERAL DIRECTOR William Reese **ADDRESS** Annapolis Md. **24a. REC'D BY REGISTRAR** Anna M.D. **24b. REGISTRAR'S SIGNATURE** Arthur L. Hanna **DATE** JAN 18 '61



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MD. 172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa, e</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oldmill Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Regina Louise Wright</u>				4. DATE OF DEATH <u>Jan. 22nd.</u> 19 <u>61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/50</u>	9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pupil</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pasadena Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Milton Robert Wright</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest Green (step father)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> <u>7/16.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped in second floor of her home which was burned down.</u>					
20c. TIME OF INJURY Month, Day, Year <u>11 24 p.m. 1/22/61</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Raubert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/23/61</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Raubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Ct.</u>		22d. LOCATION (City, town, or county) (State) <u>Manor A.A.C. Md.</u>	
23. FUNERAL DIRECTOR <u>Amiah L. Brown, Baltimore 30 Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	
				DATE <u>JAN 27 '61</u>			

RECEIVED BY THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315
JAN 10 1917

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

Very respectfully,
[Illegible Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

173

CERTIFICATE OF DEATH

Reg. Dist. No.

00092

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS 56 MADISON PLACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY BOY "A" ZIMMERMAN				4. DATE OF DEATH Month JAN Day 1 Year 19 61			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-30-60	
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME DAVID LEE ZIMMERMAN				14. MOTHER'S MAIDEN NAME SHIRLEY MAY TAYBURN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Address U. S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-30 , 19 60 , to 1-1 , 19 61 , that I last saw the deceased alive on 1-1 , 19 61 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. DATE SIGNED 1-1-61							
ACTUAL SIGNATURE J. M. Cann				M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.			
PHYSICIAN'S NAME (Type) LT JOHN J. MC CANN MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-3-1961		22c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '61	
				24b. REGISTRAR'S SIGNATURE Anthony S. Kline			

